			1 - For RegistramEND ITEM #20a 1	State of Marylar	nd / Dan	artment of h	dealth and	Mental Hygie	ene 1. No. 2001	. 01001
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Stenda Covi	natan	J, 04 GIF			2. Date of Death Month	Day Sear	3. Time of Death 11:17 A M
A.	Examir Funeral Director	ier	4a. Fecility Name (If not institution, give st 1000 1000 1000 1000 1000 1000 1000 10		last birthday) Yrs.	Balty	or Location of Deat Of Ce If Under 24 Hrs Hours Min.		(ear) Co	thplece (State or Foreign outry) th Carolina
	ryland ihow		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits
	with the Ma Re or 28s-f s	Directo	MD 10e. Street and Number 2932 Carver Road		Balti	10f. Zip Code	21225	10g	g. Citizen of What Co USA	1 Yes 2 No ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show says injury or other traumatic avent, I'm Modical Enarthrai must be rectlined at ance.	Completed by Funeral Director	11. Marital Status 11. Married Status 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1	1	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No		opecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 hou ene. then "nature he Medical E	ompleted	15. Decedent's Educing (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	rking	Sb. Kind of Business	
Maryland 2	2 should be filed and Mental Hygis ls marked other surnatic event, II.	To Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	niles
	and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship (Typ Danielle Robertso	on/daughter	29	32 Carve		ural Route Number, C altimore,		Zip Code)
Baltimore,	permit. Pages 1 Department of He Important: If iten any injury or oth		20a. Method of Disposition XXBurial 2 Cremation 3 Re 4 Donation 5 Octrer (Specify) 21. Signature of Fune all Service Licenser	moval from State	cemetery, cre	osition (Name of matory or other pla	CEMJA		SALTO	MO
Ä	Dermi Depa Impo sny ii		23a. Pert i Enter the disease, or complic shock or heart failure. List only one immediate Cause (Final	add if recto ations that caused the dea o cause on each line.	th. Do not en	altimore, ter the mode of dyi	MD 212 ng, such as cardia	01 c or respiratory arres		Approximate Interval Between Onset and Death
68760,	Lires that the death certificate be executed signed by the attending physicien and the bedtached for use as the burnaritransit.	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consection of the to	quence of):	etal	(a^C ₁ /n	ona		1. s years
P.O. Box	Attending Physician: The law requires that the death certifica rideath. •ctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a 9 Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year
Records, P	w requires that been signed b should be dete		Part II. Dther significant conditions cont	ributing to death but not re	sulting in the u	inderlying cause gr	ven in Part I.			o the cause of death?
	i iclan : The law i certificate has be rector, page 2 sh	Completed	25. Was case referred to medical						prior to death?	utopsy findings available completion of cause of
\geq	ysicle is cert direct	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Ot	200	ath (Check only one)		ecify)
Division of Vital	To the Nospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1 [ry at rk?]Yes 2 □No	28d. Describe how		, and the second
Ž	To the Höspitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci cian: To the best of my kn	owledge deat	h occurred at the ti	me date and place	City or Town,	se(s) and manner a	s stated
1/6	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examination one)	er: On the basis of examinand manner stated.	ation and/or in	vestigation, in my	opinion, death occi	urred at the time, date	e and place, and du	e to the cause(s)
ì	To the within 2 To the complet	Σ	29b. Signature and title of certifier A. M. A.	lin		29c. Licen		Ja	d. Date signed (Mon	th, Day, Year) 200 4
	Sta	ate.	30. Name and address of person who con Academic Statemen 31. Date filed (Month, Day, Year)	300) So Hu	Hano	Print)	et, Batt	House, Ma	yland 21	1225
DHI	Registi MH 17 Rev 1/2	rar	18N 2 0 2004	from to	for	S.				
					ORIGIN	IAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12, **Physician** Month Earl David Carden January 2004 11:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCL. 19, 1920 6 Sav 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 244-14-6577 100MM 2 □ F Virginia Director 83 Usual Residence of Decedent uld be filed within /c rivers.
Mental Hygiene.
Mental Hygiene.
Methet than "natural", or items 23a or 28a-f show natic event, the Medical Exertiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 632 Berry Street 21211 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XXYes 2 □ No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married soWhite Baltimore, Maryland 21215-0036 1□Yes 2₩No Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 9 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental f Health and Menta James Edgar Lola Dove Hylton Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Rohrback Daughter 634 Berry Street Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl ance. 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith 1/16/2004 Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ²² Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 rem 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, to hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ons /Medical Due to (or as a consequence of) Examiner £e. squading ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (r = a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Completed 1 ☐ Yes 2 RNo 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Division of Vital 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2. ER/Outpatient 3 □ DOA 1 Inpatient this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 📆 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 | Homicide To the Hospital hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 within ; 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 10014870 eno 0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAKCISCO de Boyiq MD 848, W. 36 STREET BALTIMORE, MD 21211 848, W. 36 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar 2 0 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 434 Year Month Physician LARG-ARE 04 HATTEN /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner DLLINGTON TCHELLVILLE If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthdey) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 F 112/1916 161-03-4819 Yrs Pennsylvania Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits th end Mental Hygiene.
7 is marked other than "natural", or liems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Funeral Director Mitchellville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 20721 parmit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23e any injury or other traumatic event, the Men 10450 Lottsford Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Maritel Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) associated broker real estate 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Fritz Peters Margaret Kaplick 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philip Chatten/son HC 72 Box 67 Ireland, WV 26376 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee ROnald S. Wad Baltimore, MD 21201 Enter the disease, con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) W12 Examiner Medical Certification: To Be Completed by Physician/Medical Examiner eral Director: After this certificate has been signed by the attanding physicien and filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requiras that tha death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) resulting in deeth) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Salve 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? TUYES 2LING 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospitel: 1 Inpatient Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2₽No 28c. Injury et Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 27. Menner of Deeth 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar death. 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune complately fi To the 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier 200 mo ld

State Registrar DHMH 16 Rev 6/95 DON

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Registrar's Signature

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

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31. Dete filed (MANDA) Year 2004

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			State State Unpend Item #1,23a,27	te of Maryland / Depa per me G828 2/5/04	artment of tas rtificate of	Health and Mo Death	ental Hygi	ene g. No. 2004	0.1.0.04
	Physici	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Channing Sayles Clifto				January	14, 2004	6:27 AM
*	Examir	ner	4a. Facility Name (If not institution, give street as Franklin Square Hospi		Rosedal	or Location of Death		4c. County of Death Baltimor	e
	Funeral		5. Sociat Security Number 6. Sex 13-92-4227 PD M 20		If Under 1 Year	If Under 24 Hrs	8. Date of Birth	O Dieth	olace (State or Foreign
	Director	П	213 72 7221	F 41 Yrs.	Months Days	Hours Min.	Oct. 7,	1962 New	York
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many I aho	ţō	Maryland Howard	Colu	mbia				1 ☐ Yes 2 X No
	th the	Jirec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
	ath w	rai	7441 Swan Point Way			045		U.S.A.	
	ier de Items	Funeral Director	Am	s Decedent Ever in U.S. 13. ed Forces? Yes 2 \(\subseteq No \)	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spec pan, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
036	al', or	Ď	If Ye	es, Give r or Dates:	1 ☐ Yes 2 🗓 No	Specify:		Specify: Bla	ck
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow the Wedical Evaluate or cultified at	Completed	15. Decedent's Education (Specify only highest grade complete	eted) 16a. Dece	dent's Usual Occu	pation during most of workin	g 1	6b. Kind of Business/In	dustry
121	within ane. then	mpi	Elementary/Secondary (0-12) Coll 1 Yea	6Q6 (1-40f 5+)		ng Technic:	- 1	Carpet Clea	ning Co
	Hygie Hygie Sther		17. Father's Name (First, Middle, Last)	darpe	C OTCALL	18. Mother's Name			illig Co.
lan	Aental Aental rked tic ev	To Be	Fred Clifton			Lucille	Sayles		
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r fraumatic event, the Med	ľ	19a. Informant's Name/Relationship (Type, Prin					City or Town, State, Zip	Code)
	fealth m 27 her tr		Alexia Clifton, Sister	20b. Place of Dispo		int Way, Co			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show amy injury or other traumatic event, the Wedical Evan and must be notified at once.		20a, Method of Disposition 1 ☐ Burial 242 Cremation 3 ☐ Removal	from State cemetery, crei	matory or other pla	ce) 01/20/1	2004	Oc. Location - City or To	
altin	nit. P vartme orteni injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee □		-	ess of Facility 555		urel, Mary nolls Rd.	rand
B	Depa Impo		P. Steven Danfelt,	0.00				olumbia,MD	21045
H			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not enter on each line.	er the mode of dy	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	ue to (or as a consequence of):					
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,09	be executed ician and burial-transit		see state and a death \ locat	ue to (or as a consequence of):					
6876	cate b	dical	d						
9 X	The law requires that the death certificate E the has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23c. If ye	s, outcome of pregnancy				23d. Date of delive	
Box.	death s atter d for u	iciar	in the past 12 months?	Live birth 2 Fetal death 3 Pregnant at time of death 5	∃Ectopic pregnand ☐ Other (specify) _	у		Month Month	Day Year
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ord	w requir been si should	eted				-	1 Li Yes	2 No 3 Prob	ably 4 □Unknown
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Vital			25. Was case referred to medical			00 Diagram of Davids	10 Yes 2	No 1 Yes	2 No
Ž		To Be	examiner? XXYes 2 No Hospital:	1 ☐ Inpatient 2X ER/Outpatier	nt 3 DOA Ot	26. Place of Death	and the second	ce 6 ☐ Other (Specify	4)
n of	0 0		27. Manner of Death 1X Naturat 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Inju	ry at 28	3d. Describe how		,,
Sio	Attending Pher death. ector: After the by the funeral	catic	2 Accident investigation		M 1	Yes 2 □No			
Division of	or At after d Direct in by	Certification:	4 Homicide determined 28e.	Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28	3f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certifying Physician:	To the best of my knowledge, deatl	occurred at the t	me, date and place, ar	nd due to the cau	ise(s) and manner as st	ated
	n 24 h	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/or in manner stated.	vestigation, in my	opinion, death occurred	at the time, date	e and place, and due to	the cause(s)
	withii To th	Σ	29b. Signatore and little of certifier	\	29c. Licen			d. Date signed (Month,	
			(Notem)	/		O.C.M.E	Ja	nuary 15, 2	4UU4
			TIA DALLEY SA	cause of death (Item 23a) (Type,	•	Ctmat B	1+	Marral and	21201
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			1 - For State Registrar	State of M	arylan	•			ealth ar Death	nd Men		ene	2004	01006
	Physici	an	1. Decedent's Name (First, Middle, La		OLINI	NENGU	0.14			_ N	Date of Death Month	Day	Year	3. Time of Death 4:20 A M
	/Medic	_	HAZEL E 4a. Facility Name (If not institution, gin	ILENE		NINGH		Town or	Location of I		anuary		,2004 ounty of Death	4:20 A
P	Examin	er	Avalon Manor Heal			,	1		stown				lashin	aton
-	Funeral		5. Social Security Number 6.	Sex 7. Ac		last birthday)	If Unde	r 1 Year	If Under 24		Date of Birth Month, Day,		9. Birth	place (State or Foreign
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	DC >	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or Lo	cation							10d. Inside City Limits
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9	after or ite	Ţ	1 Never Married 2 Married	Armed Forces 1 Yes 2 1 If Yes, Give	No	i			Specify:	Pueno Ricai	n, etc.)		Black, White,	etc.
8	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Madical Examiner must be motified at	d by	3 ₩ Widowed 4 Divorced	Year or Dates:			1 1 1 1 1 1 1 1 1 1 1	21,4110	Зреспу.					nite
<u>7</u>	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of E (Give kind of work done during most of working life. DO NOT use retired)									of Business/In	dustry			
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ore	iges 1 ar of Hea iffitem; or other		20a. Method of Disposition 1X Burial 2 □ Cremation 3 (14 □ Donation 5 □ Other (Special Control of the Contr	☐Removal from State	20b. P	Place of Dispo emetery, crea	natory or	other place		Date			tion - City or To	
Ë	Pag ment tent: jury c		TEDONIZION CESCINO (OPON	.,,,	Park									, Marylan
Baltimore,	permit. Pages. Department of the Importent: If ite any injury or of once.		21. Signature of Euneral Service Lice	Brady	_	40	Las	L AIIL	<u> teram</u>	Stree		<u>jers</u>	Inc. town, M	ld. 21740
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause y one cause on each l	d the deat line.	h. Do not ent	er the mo	de of dying	g, such as ca	ardiac or res	piratory arres	t,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aA	cut	My	vu	۸-4-	e In	para	tie			to min
н	/Medical Examiner		1	Due to (or as		-								4 .
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as		uence of):	120							*
V	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c										
oʻ	cate be executed oblysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	s a conseq	uence of):								
8760,	ate be nysici he bu	Physician/Medical		d										
9	death certifical e attending phy ed for use as th	Med	IF FEMALE:				·							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Feta	Ideath 3	Ectopic					230	d. Date of delive Month	ery Day Year
P.O.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant a 9⊡ Unknown	at time or a	eath 5	Other (s	рөспу)						
	law requires that the de as been signed by the 2 should be detached	F.	Part II. Other significent conditions	contributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did toba	cco use	contribute to t	he cause of death?
Vital Records,	w requires that s been signed to should be det	d by	Disbrits 1	mace tens							1 🗌 Yes	2 🗆	No 3 ☐ Prot	oabiy 4 🕮 Rnown
ဝ္ပ	w rec	Completed									24a. Wasan	1:	24b. Were auto	ppsy findings available
Be	0 - 0	E O									autopsy performe 1 ☐ Yes 2 [d?	prior to co death? 1 ☐ Yes	mpletion of cause of
tal	ticien: Th certificate rector, pag	O	25. Was case referred to medical						26. Place o		eck only one)		1 🗆 163	2010
<u> </u>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1Inpat	ient 2	ER/Outpatier	nt 3 D	OA Othe	9r: 4 4 Nurs	sing Home	5 🗌 Residen	ce 6[Other (Special	(y)
n of	ng Ph Iter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Date	ury ay Yeer)	28b. Time o Injury	f	28c. Injury Work	at ?	28d.	Describe how	injury o	occurred	
Sio	Attending ir death. ector: After by the fune	catle	2 Accident investigation	he			М		res 2 □ No					
Division	iel or Attends after death al Director:	Certification;	3 Suicide 6 Could not 4 Homicide determine	288. Place of it	njury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factor	ry, office			_ocation (Stre City or Town,		Number or Rura	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical		hysician: To the besi miner: On the basis and manner s	of examina									
	To the within 2 To the complet	ž	29b. Signature and title of certifier				29	c. License			- 1		signed (Month,	•
			- (2) LE !	10				() ()	४०।५		-	140	v 15,	2004
	4		30. Name and address of person who	·	death (Iten		Print)	J 7	MAG	CP1	701~	/	~0 =	21746
	Sta		31. Date filed (Month, Day, Year)		r's Signa		Lo	WE)						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Year **Physician** Beatrice С. Castro 2004 1:45 PM 17, January /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Williamsport Nursing Home Washington Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Months 1 ☐ M 2 ☐ XF Yrs. 99 Director 214-20-1352 JAN 26. 1904 | Maryland Usual Residence of Deceden Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: if Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 505 Hilton Avenue 21228 **USA** 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Manufacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oscar C. Middlekauff Isabel Southgate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Lushbaugh/Friend 17719 Mason Dixon Road Hagerstown MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: if any Injury or pace. ò Metro Crematory Inc. Baltimore, MD 1-18-04 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation Society of MD, Inc. homoe ! Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical breast cancer 9 months Examiner Due to (or es a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of) end Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? atherosclerotic heart disease 1 Yes 2LIN 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 24 hours after death.
Funeral Director: After this ataly filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide the cospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner steted. To the Hosp within 24 hos To the Fune complataly fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 17, 2007 D47451 anthe Kuttner- Sando in 30. Name and address of person who completed cause of death (Item 230) (Type, Printy ursing Home, 154 North Artizan Street

Registrar DHMH 16 Rev 6/95

State

Cynthia Kuther-

JAN 2 0 2004

31. Date filed (Month, Day, Year)

Catherine

Beatrice

MD.

32. Pegistrer's Signature

Williamsport Maryland 21795

			1 - For State Registrar	State of Ma	arylan		artment of H		nd Mental H	lygier Reg. !	-201	A Section	01008
	Physici	an	1. Decedent's Name (First, Middle, Las	·			0		2. Date of Month			əar	3. Time of Death
	/Medic	al	JEROME A. COLLI. 4a. Facility Name (If not institution, give				4b. City, Town, or	r Location of	JANUA Death		5, 200 4c. County of		11:00 PM
	Examin	er	221 RIDGEMEDE RO		507			MORE C			N/		
	Funeral		5. Social Security Number 6. S		e (in yrs.	last birthday)	If Under 1 Year Months Days	If Under 24		Birth Qay, Yea			ace (State or Foreign
	Director		577-32-1971 Usual Residence of Decedent	UM 2UF	83	Yrs.			12/6	/1920	O F	LOR	
	ow #		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	Od. Inside City Limits
	e-f eh	ctor	MD N/	'A	E	BALTIMO	DRE CITY						1∭Yes 2☐No
	or 28	Dire	10e. Street and Number	//٢٥	~		10f. Zip Code				Citizen of Wha	t Coun	try?
	s 23e	eral	221 RIDGEMEDE RO	AD #50		S 13 1	2121 Was Decedent of H		n? (Specify Yes or		USA 14. Race -	Americ	an Indian.
(0	r Itam	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🛐	•		f Yes, specify Cuba	an, Mexican, I	Puerto Rican, etc.)		Black,	White, 6	etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Itams 23e or 28e-f ehow wit, the Medical Examination and the morified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:			Specify:		ITE
15. Decedent's Education 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kin MARK								Kind of Busin	ess/Inc NTE	lustry R			
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Elementary/Secondary (0-12) 4+ YEARS EXECUTIVE									VELOPME	ENT	CORP.		
	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28e-f show termatic event, Ire Madical Extra illustratural be notified at	BeC	17. Father's Name (First, Middle, Last)						s Name (First, Mid		(e <i>n Suma</i> me)		
yla	should the marked umatic of	ဥ	JEROME COLLINS			105 11-77	ng Address (Street		NE BRUSS			A- 77-	0-4-1
Maryland	and 2 st ealth and n 27 is n	9 8	19a. Informant's Name/Relationship (IFE		RIDGEMEDE		507 BALT			212	
	f Heal	1 3	SANDRA H. COLLINS 20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place	(9)	Date	-	Location - Cit		
Ë	Pages ment of ant: If It ury or o		1 🖾 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify				GARBENSE		/20/2004	T	IMONIUN	1, M	D
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any injury or other treumatic 2006.		21. Signature of Funeral Service Licen	see			2. Name and Addres		TILL COIN				OME, P.A.
	10244	23a Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											Approximate Interval Between
E	Physician	-	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	ine.	och	100	uit-	faction	,			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	,oc pa) (0)	1			J' 3
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	uted d ansit	Examiner	cause. Einer Uniderlying Cause (Disease or injury that initiated events			201,000 01/2							
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8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Physiclan/Medical		d									
9 X	attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of	f delive	rv
. Box	ne death the atter hed for u	iclar	in the past 12 months? 1 Yes 2 No	1 Live birth 4 Pregnant a			Ectopic pregnancy Other (specify)	<u>'</u>		_	Month		Day Year
P.O.	that the death ed by the atte detached for	Phys	9 Unknown	9□ Unknown		ulaine in about		anda Banki	220 0	id tabasa	o una contribu	to to th	e cause of death?
	es pe	by	Part II. Other significant conditions of	ontributing to death t	out not res	uiting in the u	nderlying cause giv	en in Fan I.		☐ Yes	_	∏ Proba	
COL	w requir	lete							24a. W	/as an	24b. We	e autop	osy findings available
Vital Records,	The lav	Completed							a pi 1 ☐ Ye	utopsy erformed s 2 2	prio dea	r to con th?	npletion of cause of
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place o	f Death (Check or				
of <	Physician: r this certific ral director,	은	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		ER/Outpatier		4 11015	ing Home 5			Specify)
on o	ding h h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iy Year)	28b. Time of Injury	Wor	yat k? Yes 2.⊟No		oe now in	ijury occurred		
Division	l or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined		jury - At ho	ome, farm, str	eet, factory, office		28f. Locatio	n (Street Town, St	and Number	or Rurai	Route Number,
Ö	ital or A irs after rel Direc led in by		Tomode	Dullding, et		y/ 			Ony or				·
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	To the within 2 To the comple	Med	29b. Signature and tipe of certifier	1			29c. Licens	e number		29d. [Date signed (A	Aonth, (Day, Year)
	1		> Man la	mul	M	Δ	DS	5)+	3		1-11	_ و	04
	8		30. Name and address of person who		death (Item	A 0	Print)	1.0.	CL TO	11	01.1		12011
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			For State	State of Mary	ylanu i	•	rtificate of L		ועו טווג		0.0	nnı.	01000
			Registrar 1. Decedent's Name (First, Middle, I	ast)			tineate of L	Jean		2. Date of Dea	Reg. No. 🔏 👢	/ U 46.	3. Time of Death
	Physici	an	TORROLD	M. Cohl	n					Month	Day	Year	IN44 AM
> -	/Medic Examin		4a. Facility Name (If not institution, g	rive street and number)			4b. City, Town, or	Location of	of Death		c. County	of Death	
	LAUIIII		University of	Maryland			Balt	MU	al_				N/A
	Funeral			Sex	In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	if Under Hours	24 Hrs. Min.	8. Date of Birt Month, Da NOV . 23	h y, Year) 10/12	9. Birthp Cour	olece (State or Foreign htry)
	Director		219-38-3420 Usuel Residence of Decedent	Χ	61	113.				1104.23	,1942	·	טויו
	yland		10a. State 10b. County	1	Oc. City, T	own or Lo	ocation			_		1	0d. Inside City Limits
	e Mar	ctor	MD BAI	_TIMORE		BAL	TIMORE						1 □ Yes 2 No
	in the	Dire	10e. Street and Number	DOAD			10f. Zip Code	212	200		10g. Citizen of	What Cour	u.s.A.
	a 23a	erai	8405 STEVENSON	12. Was Decedent Eve	er in U.S.	13	Was Decedent of Hi	212		ecify Yes or No	- 14. Ra	ce - Americ	
.	fter de r Itam	Fu	11. Marital Status 1 □ Never Married 2 🕅 Married	Armed Forces?	o, iii o.o.		Was Decedent of Hi If Yes, specify Cuba		n, Puerto	Rican, etc.)		ck, White,	
036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Itama 23a or 28a-f show of other than "natural", or Itama 20a or 28a-f show event, the Medical Examirae must be rediffied at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No	Specify:			Specia		WHITE
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9	e filed within al Hygiene. other than '	Be Co	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle,	Maiden Sumai	me)	
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Maryland 21215-0036	2 2 2 2		19a. Informant's Name/Relationship				ng Address (Street a						
, N	of Health item 27		LINDA COHEN / 1 20a, Method of Disposition	WIFE	20b. Plac		STEVENSO			BALIIMO	20c. Location		
Baltimore,	0 C - 1-		1 XBurial 2 ☐ Cremation 3	Hemoval from State			osition (Name of matory or other plac LOM MEMOR		KK.	5/2004			OWN, MD
Itin			* 4 □Donation 5 □ Other (Spe 21. Signature of Funera) Service Lig		UNCE		2. Name and Addres				VSON & I		
Ba	permit. Departr Imports sny inj		1 Mant				8900 REIS	TERS1					MD 21208
á	4		23a. Pert1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the	e death.	Do not en	ter the mode of dyin	g, such as	cardiac (or respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a d	consequer	nce of):							
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8760,	eath certificate be executed attending physician and for use as the burial-transit	lical	,	d									
x 68	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	pregnanc	v					22d D	ate of deliv	on.
Вох	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	☐ Fetal de	eath 3	□Ectopic pregnancy □ Other <i>(specify)</i>	,				onth	Day Year
o.	that the de ed by the a detached	Physician/Medi	1 Yes 2 No 9 Unknown	9☐ Unknown						_,			
S, D	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	by P	Part II. Other significant condition	s contributing to death but	not resulti	ng in the u	underlying cause give	en in Part I	l.	23e. Did t	obacco use cor		he cause of death?
ord	w require been sig should b									1 🗆 '	Yes 2□No	3 Prot	pably 4 Dunknown
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al H										1 Yes	2\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 Yes	2 No
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	this alo	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)		8b. Time o		v at			how injury occu		97)
ion	death. ctor: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	r Gar)	mjury		Yes 2 🗆	No				
Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			e, farm, st	reet, factory, office			28f. Location (City or To	Street and Num wn, State)	ber or Run	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After or mpletely filled in by the funer		29a, Certifier 17 Certifying	Physicien: To the best of	my knowle	edne dea	th occurred at the tir	ne date ar	nd place	and due to the	cause(s) and m	anner as s	stated
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical E	xeminer: On the basis of e	xaminatio	n and/or i	nvestigation, in my o	pinion, dea	ath occur	red at the time,	date and place	and due t	o the cause(s)
Soi.	To the virthin 2 To the complete	Me	29b. Si nature and title of certifier				29c. Licens	e number	0700		29d. Date sign	ed (Month,	Day, Year)
			NAV.	IMD			PIF	010	44		Janua	Ry 1	5,2004
	(1		30. Name and address of person w	ho completed cause of dea	ath (Item 2	(Type	, Print)		Res.	772	Le te	0	501701
)		31. Date filed (Month, Day, Year)	√ 32 Registrar	's Signatur	x d	2 010	CIV	9	DXU	THE VICE I	2	1) UW
	St Regist	ate trar	JAN 20 2	2004	e St	200	all						
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			For State Registrar	State of Mary		artment of F			giene Reg. No2 0 0 1	. 01010
			Negistrar Decedent's Name (First, Middle, Last)			ranoato or		2. Date of Dea	ath	3. Time of Death
Æ	Physicia		Ali	ice I. Ca	ashen			Month Januar	y 14 2004	
).	/Medic Examin		4a. Facility Name (If not institution, give str		<u> </u>	4b. City, Town, o	r Location of Death		4c. County of D	
	LAGITIII	C1	8003 Theresa Rose	e Lane		Sever	'n		Anne i	Arundel
	Funeral		5. Social Security Number 6. Sex	4 2157 =	yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year) 9.1	Birthplece (State or Foreign Country)
	Director		008 09 2285	8	7 Yrs.			Oct. 15	5, 1916	Vermont
	and w	}	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	ō	Maryland Anne Aru	inde1	Severn					1 ☐ Yes 2X No
	r 28a	rec	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of What	Country?
	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show he Modisal Examitter count by notified at	Funerai Director	8003 Theresa Rose	e Lane		21	144		U.S.A	•
	ams ams	ner	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No ff Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
Ö	hour		15. Decedent's Educa	Year or Dates:	16a, Dece	edent's Usual Occur	pation		16b. Kind of Busine	ss/Industry
15	n "n	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) Colfege (1-4or 5+)	(Give	B kind of work done DO NOT use retire	during most of word)	king		
212	d with giene ir the	Completed	11th	College (1-401 3+)	Hom	emaker			Own	Home
b	be filed htal Hygid of other event, II	Be	17. Father's Name (First, Middle, Last) Hormidas	Viena				ne <i>(First, Middl</i> e, Bonneau	Maiden Sumame)	
y la	should to Ment marked umatic	ဥ								
Maryland 21215-0036	C/ G = 0		19a. Informant's Name/Relationship (Type M. Debra Jenkins			ing Address (Street Theresa			er, City or Town, State rn, Maryla	
	1 and Health em 27 thar t	-	20a. Method of Disposition		0b. Place of Disp	osition (Name of		Date	20c. Location - City	
Baltimore,	Pages nent of I int: If it		1 🖾 Burial 2 □ Cremation 3 □ Re	moval from State	cemetery, cre	ematory or other places SS Cemete		/2004		, Maryland
턡	permit. Page Department o Important: If any injury or once.		4 □Donetion 5 □ Other (Specify)21. Signature of Funeral Service Licenses		_					al Home, P.A
Ba	Depa Impo sny ii		1. Shannon	Higan	11	1001 Ritch	hie Highw	ay Bal	timore, Ma	ryland 21225
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	death. Do not er	nter the mode of dyin	ng, such as cardiad	or respiratory ai	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metastar	12 Th	moid	Cance-	1		Onset and Death
	/Medical		resulting in death)	Due to (or as a co		1				
Я	Examiner		Sequentially list conditions. b.	ment	- land	4				
0	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a co	nsequence of):					
	and and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of);					
760,	ate be executed hysician and he burial-transit	cai E								
687	ficate physics the	g	0.							
Вох	anding use a	Z/W	IF FEMALE: 23b. Was decedent pregnant	c. ff yes, outcome of p 1 ☐ Live birth 2 ☐		The table processes	.,		23d. Date of	
m.	death e atte	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
P.O.	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/M	9 Unknown							
	res tha igned be del	by	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did t		e to the cause of death?] Probably 4 □Unknown
Vital Records,	w require been si	Completed						-		
Sec	e law has b ge 2 sl	nple						24a. Was autop	an 24b. Were prior death	autopsy findings available to completion of cause of
alF	Th ate pag							1 ☐ Yes	200 No 1 1	res 2□ No
Ĭ,	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 C E D (0. 12-14)	0th	200	ath (Check only o	one) dence 6 □Other (S	N===(4:1)
ō	Physic this aral di	 -	27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	of 28c. Inju	ry at		how injury occurred	респу)
on	Attending r death. sctor: After oy the fune	tlor	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day Ye	ar) injury	M 1	rk?]Yes 2∐No			
Division	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (5	At home, farm, s	treet, factory, office		28f. Location (S City or Tox		Rural Route Number,
Ö	tal or A	Certification:	4 I HOMOGO	Sullaing, oto. (c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				,	
1	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical		cian: To the best of mer: On the basis of exa	amination and/or i					
-	Fo the Mithin 2 Fo the comple	Mec	29b. Signature and title of certifier	and marrier stated	ш.д.	29c. Licen:	se number		29d. Date signed (M	onth, Day, Year)
	F * F 5		1 1the il	17	u.U.	101	42820		1/15/04	
	()		30. Name and address of person who con	npleted cause of death	(ftem 23a) (Type	0:0				
	9		Chris de Bori	a 3708	3 mou	intain	Rd.	Pasac	leng, m	66115 611

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			For State Registrar	State of Maryland		artment of H tificate of L			iene •g. No2 () (01011
	Physici		1. Decedent's Name (First, Middle, Last)	Emma M. Conf	air			2. Date of Dea Month	Day	Year 2004 6:05 A.M
1	/Medic		4a. Facility Name (If not institution, give si		all.	4b. City, Town, or	Location of De	Januar ath	4c. County of	
	Examin	er	302 Arden Road			Balti	more		Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la 76	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year) 1927	9. Birthplace (State or Foreign Country) Maryland
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28.	Oire	10e. Street and Number			10f. Zip Code	005	1	Og. Citizen of W	
	ath w	ra	302 Arden Road	O Was Deceded Ever in 115	12.1		225	(Specify Ves or No-		• A •
920	d within 72 hours after death with the Maryland Jene. r then "naturel", or items 23s or 28s-f show the Madrial Examinat court be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 → No	Specify:	(Specify Yes or No- erto Rican, etc.)		k, White, etc.
21215-0036	in 72 hor	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired	during most of v f)	vorking	16b. Kind of Bu	siness/Industry
212	d within giene. er then	mo:	8th	College (1-40/ 5+)	Loa	n Officer			Banki	
Maryland	uld be filed a Mental Hygid irked other itic event, the	To Be C	17. Father's Name (First, Middle, Last) Bernard	Foit			Jen	nifer Pan	zer	
lary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type				_	Rural Route Numbe		
	s 1 and f Health item 27 other tr		John Confair Sr. 20a. Method of Disposition		44	Arden Roa	α	Balt1mo Date		y1and 21225 City or Town, State
זסר	m O		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	metery, crei	natory or other place n Mem. Pa	· 1	7/2004		tsville, MD.
Baltimore,	permit. Page Department Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		1 20	2. Name and Addres	ss of Facility Geo	orge J. Go	once Fun	neral Home, P.A. Maryland 21225
10,	Physician /Medical Examiner physician and physician and the prijel-transit the prijel-transit physician and the prijel-transit physician and p	Examiner	23a Part1. Enter the disease, or complishook, or heart failure. List oply on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):			enanyd		Approximate Interval Between Onset and Death
P.O. Box 68760,	the death certific by the attending pached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[□Ectopic pregnancy □ Other (specify) _	1		23d. Date Mor	e of delivery nth Day Year
	quires that n signed t uld be det	by	Part II. Other significant conditions cor	ntributing to death but not resu	itting in the u	inderlying cause giv	en in Part I.	361		ribute to the cause of death? 3 □ Probably 4 □Unknown
I Records,	The law require ate has been si page 2 should l	Completed	J	J				24a. Was autop perfor 1 \(\text{Yes} \)	sy pomed?, d	Were autopsy findings available prior to completion of cause of death? □ Yes 2□ No
Vital	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	fospital:		Oth	000	Death Check only o		
of	는 무를	2	1 ☐ Yes 2 ☐ No 27. Manner of eath	1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	4 Nursin		lence 6 Othe	
Division	ding Afte fune	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year) 28e. Place of Injury - At ho	Injury	M 1 🗆	k? Yes 2 □ No			er or Rural Route Number,
Div			4 Homicide determined	building, etc. (Specify	·)			City or Tow		and as stated
1	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	tion and/or in	nvestigation, in my o	ppinion, death o	ccurred at the time, o	date and place, a	and due to the cause(s)
	Tot With Tot	Z	29b. Signature and title of certifier			29c. Licens	se number 352	34	zyd. Date signed	d (Month, Day, Year)
	4		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type	Print) VE BAC	TM	72155		
	St	ate	31. Date filed (Month, Day, Year)	32. Regetrar's Si na	ture &	Span	the same			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 9:40 PM Januar 16 2004 oma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Baltimore Hospital Singi 01 If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, 9./Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1☑M 2□F Yrs. 215-28-050 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-1 show the Medical Examiner must by notified at 100€Yes 2□No Maryland Completed by Funeral Director ons 10g. Cilizen of Whal Country? 10f. Zip Code 10e. Street and Number 212 2 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Şecondary (0-12) College (1-4or 5+) Stodian 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental neu ဥ (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patient Known Department of Health a Important: If item 27 is any injury or other tre once. Ton 20c. Location - City or Town, Slale 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2004 Son Forest * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service/Licensee ercu North Ave 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopy, or heart failtire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acule Inarction myccardial 12 hours Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 years disease Coronary astery Saturated by list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and 3 in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnan| at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ hypertipidemia, Diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2戊 No vascular Deriphira 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number

50

Vishaypnya 31. Date filed (Month, Day, Year) JAN 2 0 2004

30. Name and address

29b. Signature and title of certifier (

32: Registrar's Signature

2461 West Belvedere

berson who completed cause of death (Item 23a) (Type, Print)

MD

290/21

KES

Avenue

000

Baltimore

16,2004

21215

Maruland

Registrar

			1 – For Registrar	State of Ma	arylar				ealth a		Mental Hy	gien Reg. N	201	1	01013
			Decedent's Name (First, Middle, Last	st)							2. Date of D		U. (()	J 49	3. Time of Death
	Physici		Doris Mae Clark								Month	Da	•	ear Doil	1.77 5W
>	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			4b. Cit	y, Town, or	Location of	of Death	HOME		c. County of	-	
	LXamii	ici	GOOD SAMAR	H eggs	- No.	TAL		BAL-	TIME	- R		P	altim	ore	City
т	Funeral		5. Social Security Number 6. S	ex 7. Ag		last birthday)	If Und	er 1 Year	If Under	24 Hrs.		rth .	, g		lace (State or Foreign try)
	Director		214 22 3332	□M 2□F 81	1	Yrs.	Month:	Days	Hours	Min.	8. Date of B (Month, D March 9	1922	F	al ti	more Co., MD
	P		Usual Residence of Decedent												
	show	_	10a. State 10b. County			ty, Town or Lo								11	0d. Inside City Limits
	Ba-f	cto	Maryland Baltimore		Bal	timore C	ounty	,							1 ☐ Yes 2 ☐ No X
	ith th	Director	10e. Street and Number				10f. 2	ip Code				10g. C	itizen of Wh	at Coun	try?
	ath v	Funeral	8126 Dalesford Road					21234				USA,			
	er de Item	nu	11. Marital Status	12. Was Decedent Armed Forces?			Was Dec f Yes, sp	edent of Hi ecify Cuba	spanic Ori n, Mexican	gin? (Sp 1. Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,	America White, 6	
36	rs aft	by F	12 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	NO		1 □ Yes	2 🗓 No	Specify:				Specify:W	hite	
Ş	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Madical Exactinat must be routiled at	- Pa	15. Decedent's Ed			16a. Deced	dent's Us	ual Occupa	ation			16h I	Kind of Busin		lustry
15	n n	Completed	(Specify only highest gra	de completed)		(Give	kind of v	ork done d use retired	luring mosi)	t of work	ing	102.1	and or buon	100001110	a stry
72	d within piene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5	1+)	Clerk						Bla	ck & De	cker	
Þ	a filed If Hygi other	0	17. Father's Name (First, Middle, Last)						18. Mothe	r's Nam	e (First, Middle	, Maide	n Sumame)		
ā	Mental Mental arked c	To B	George D Clark						Myrt	le I	Evans				
Maryland 21215-0036	s ma		19a. Informant's Name/Relationship (Гуре, Print)		19b. Mailir	g Addre	s (Street a			al Route Numb	er, City	or Town, Sta	ate, Zip	Code)
Σ	and 2 salth n 27 I er tre		Grace I Clark			8126 D	alesf	ord Ro	ad Ba	ltim:	re, Mary	land	21234		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic en		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Romaval from State	20b. F	Place of Dispo	sition /N	ame of	1		Date		ocation - Ci	y or To	wn, State
Ĕ	Pag nent ant: I		`4 □ Donation 5 □ Other (Specify		Par	ckwood G	amete	ry Jan	uary 1	6 200	<u>Y</u>	Balt	imore,	Mars	alam)
att	permit. Departr Imports any inju		21. Signature of Funeral Service Licen	See *		22	. Name a	and Addres	s of Facilit	v			,	, Lucy	10.0
m	89 E 29		100 How Pise	and man	DOK	1	Lassa 7401	u run Pelair	eral H Road	one i Ralt	nc imore, M	brylo	md 212	36	
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused one cause on each lin	the deat	h. Do not ent	er the mo	de of dying	, such as	cardiac	or respiratory	rrest,	4 K.1 Z.1Z.		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a INTRA	ERA	LAIM	7.	FEIM	ORRI	HAC	- ==				Onset and Death
	/Medical		resulting in death)	Due to (or as				1 Carried of A	0 14/4		7				20442
н	Examiner		Sequentially list conditions,	b										ļ	
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Ő,	e execution a	Ě	resulting in dealin, cast	Due to (or as	a conseq	ruence of);									
8760,	cate be executed physician and the burial-transit	dlcal	•	d											
9	eath certific attending p I for use as	- ω +	IF FEMALE:	000 14		NATE OF THE REAL PROPERTY.	-								
Вох	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	l death 3		oregnancy					23d. Date of Month		y Day Year
	0 0	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of d	leath 5∟	Other (s	pecify)						,	,
P.O.	The law requires that the de ste has been signed by the a page 2 should be detached f		Part II. Other significant conditions of	ontributing to death by	it not res	ulting in the u	nderhring	cause dive	n in Part I		23e Did	tobacco	use contribu	ite to the	e cause of death?
Division of Vital Records,	signe signe d be	b	and to the same of	SORDER		annig in the di	donyang	ouuso give				Yes 2			ably 4 □Unknown
Ö	w requir been si should	Completed		19011021						_	-		APPLIAN OF		
Sec.	elaw hasl	du									24a. Was	psy	prio	r to com	sy findings available pletion of cause of
-		S									1 Tes	ormed?	dea 1 □	Yes :	2 3 No
<u>Sit</u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0		of Death	(Check only	one)			
of	S S	2	1 Yes 2 No	1 Zmpatie		ER/Outpatien			4 Nui		me 5 Res			Specify,	
Z .	ing After une	lon	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		28c. Injury Work			28d. Describe	how inju	ry occurred		
Sic	Attending r death. ector: Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		unu At hu		M		/es 2□N		28f Location	Stroot a	and Advantage of	or Owen	Courte Mountain
<u>></u>	5 # # E	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc			et, racio	ry, office			City or To	wn, State	e)	or Hurai	Route Number,
_	Hospital or 24 hours afte Funeral Dire tely filled in b	ŭ	29a. Certifier 1 Certifying Ph	ysician: To the best of	of my kno	wledge door	0001170	d at the tim	e date ac	d place	and due to the	00110-1-	l and	NF 00 04-	tod
	24 hos 24 hos Fun etely	ledical		niner: On the basis of and manner sta	examina	ition and/or inv	estigatio	n, in my op	inion, deat	h occurr	ed at the time,	date an	d place, and	due to	the cause(s)
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier				29	c. License	number			29d. Da	ite signed (A	Month, D	Pay, Year)
	/		* BNyonato	m. mr	>			REC	00	0	~	50		17	, 2004
-	0		30. Name and address of person who			n 23a) (Type	Print)	E		N	OMAT	~ 17 IJ	101412	12	1 2004
			GOOD SAMARIT			AL,	The Car	I DE	26.17	Rais	EN Q	00	1200	1/1	PESIS Q.
	Sta		31. Date filed (Month, Day, Year)	32. Regist/			100	40		, ,,,,,,,	-14 120	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	14147	/ (4)	1 21-21
	Registr		JAN I	1 ZUU4 > 12	Children	1 15	A DO	A Land							

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DORIS

		1 - For Amend Item@lper		yland / Depa		Health and	Mental Hy		
Physici /Medio Examin	al	Decedent's Name (First, Middle, Last A. Facility Name (If not institution, give	CVia		st.	or Location of Dea	2. Date of Dea Month Januar	Day Yes	
Funeral Director			_	In yrs. last birthday) Yrs.	Baltimo If Under 1 Year Months Days	If Under 24 Hr		Baltimo 9 1930 Bal	re City Birthplace (State or Foreign Country) timore City,MD
72 hours after death with the Maryland 72 hours after death with the Maryland natural; or flems 23e or 28e-f show lice Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore (10e. Street and Number		Oc. City, Town or Lo	2				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
teath with	Funeral Dir	1236 Sheridan Avenue	12. Was Decedent Eve	er in U.S. 13.1	10f, Zip Code 21239	Hispanic Origin? (10g. Citizen of What	merican Indian.
17-20030 172 hours after death with the Marylan "natural", or Nems 28a or 28a-f show cilical Exprojeer navat be notilised at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【文Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)	Black, W	hite, etc.
t within jiene.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire CLerk	during most of we	orking	16b. Kind of Busine	ss/Industry rity Aminist.
Mental Hy Mental Hy arked other	To Be C	17. Father's Name (First, Middle, Last) Giuesppi Orlando 18. Interpretis Name (Relationalis (T.	To Cried			Dora Bo	ame (First, Middle,	Maiden Sumame)	
C = 14 F		19a. Informant's Name/Relationship (T) Martin E Chojnacki (So 20a. Method of Disposition	n)	583 Fe	lix Court	Bel Air	Maryland Date		
permit. Pages 1 a Department of Hes Important: If item any njury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	ioniova nom otato	20b. Place of Dispo cemetery, cren Gardens of		. January	15 2004	Baltimore, M	
Physician Medical Examiner We partial-transit Physicial Physician and Physician and Physician and Physician and Physician and Physician Phys	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c		4 pm a	tion	- Pheur	mm'a	Onset and Death 24 horrs 22 minus
the death certific y the attending pl iched for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	delivery Day Year
် အ မ်ာ့ ဆွ	by	Part IV Other significant conditions con	ntributing to death but n	pot resulting in the unit $\rho a/s$	derlying cause give	en in Part I.		10	to the cause of death? Probably 4 □Unknown
The ate h	e Completed	25. Was case referred to medical		/			24a. Was a autops perform	sy prior to med? death? 2∰No 1 ☐ Ye	autopsy findings available o completion of cause of ? es 2 \(\text{No}\)
ding Phys	ToB	examiner? 1	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2@ER/Outpatient 28b. Time of Injury	28c. Injun Work	er: 4 🗆 Nursing H	7	ence 6 Other (Sp ow injury occurred	pecify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune	I Certification;	3 Suicide 4 Homicide 6 Could not be d Jumms 29a, Certifier 12 Certifying Phys	28e. Place of Injury building, etc. (5	Specify)			City or Town		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical Examination of ortifier	sician: To the best of more: On the basis of example and manner stated	amination and/or inv	estigation, in my op	pinion, death occu	urred at the time, da	ause(s) and manner a ate and place, and du	ue to the cause(s)
6	1	30. Name and address of person who co	mpleted cause of death	n (Item 23a) (Type, F	Print)	2733	4 D	Jan 1	72/04 MAN
Stat Registra	-	31. Date filed (Month, Day, Year)	7 2004 Registre's	Signature	South	uno CI	011 74	JOHN -	resing IMI

				For Stete Registrar	State of	Maryland / De	partmer ertificat			nd Ment		ene 1. No. 2	004	A THE P PAGE	015
		Dhuaisi		1. Decedent's Name (First, Middle	, Last)						ate of Death	Day	Year	3. Time of	
		Physicia /Medic		Mary Duquette							inuary	17	2004	5:22	. A M
U		Examin	er	4a. Facility Name (If not institution			- 1		Location of			4c. Cour	nty of Death		
				5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	(V) If Unde	1 Year	If Under 24		ate of Birth fonth, Day, 1		N/A 9. Birthp	lece (State o	or Foreign
		Funeral Director		020-20-5784	1 ☐ M 2 💢 F	84 Yrs	Months	Days	Hours	Min. (N	fonth, Day, \ /04/19	^(ear) 919		ine	
		pu ,		Usual Residence of Decedent		10c. City, Town or	Location							0d. Inside Ci	ity Limite
		shov	'n		•	roc. City, Town of							'	1 Tyes	
		death with the Maryland rms 23e or 28e-f show ricust be notified at	Director	MD Balt 10e. Street and Number	imore		Relay 10f. Zi	Code			100	g. Citizen o	of What Cour	try?	
		3e or	Ö	508 Gun Road					21227		ļ		USA		
		death	Funerai	11. Marital Status	Armed For	dent Ever in U.S. 1	3. Was Dece	dent of H		n? (Specify Y Puerto Rican	es or No-		ace - Americ		
	98	or items		1 Never Married 2 Marr	ied 1 📉 Yes If Yes, Giv	2 No	1 Tes		Specify:		, 0.0.,	Spe	cify-		
	Ö	72 hours after "natural", or Ita	ed by	3 Widowed 4 Divorced	Year or Da		cedent's Usu	al Occup	ation		1 1/	Sh Kind of	Business/In	hite	
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ڲ	ם	be filed tal Hygi d other evant, I	Be (17. Father's Name (First, Middle,	Last)				18. Mother:	s Name (Firs	t, Middle, Ma	aiden Sum	ame)		
a	Maryland 21215-0036	Men Men arke	은	Charles Gregory		105.14	- ita - Addisa	/C1==1		nnie D		City or Tou	- Ctata Zin	Code	
Duquerre	Mai	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relations						o <i>r Rurai R</i> ou			т, Зіаів, Дір	C000)	
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3	Ę	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S	3 □Removal from : pecify)	Balto-Wa	•			/21/20	04	T.au	rel. M	D	
A	altimore,	permit. Pages Department of I Important: If Iti eny injury or o		21. Signatura of Funeral Service						Schwab					
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_			6	23a. Patt1. Enter the disease, or shock or heart fallure. List	complications that conly one cause on e	aused the death. Do not ach line.	enter the mo	de of dyin	g, such as ca	ardiac or resp	oiratory arres	t.		Approximat Interval Bet Onset and I	e ween Death
		Physician /Medical		Immediate Cause (Firm) disease or condition resulting in death)	a. Acute	Respirator	y D1:	tres	s Sy	ndrow	ve_			2 wk	S
16		Examiner	П		M. bus	or as a continuence of):		D	· ,					21.100	Le
	Sequentially list conditions, if any leading to immediate cause. Enter Underlying						non,	псм	10					عاسرو	150
		and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a Mitro	1 Value R	<u>pair</u>	Su	rgery					3 weel	دح
	760,	ite be executed ysicien and ne burial-transit	cal Ex	resulting in deathy Last	Due to (or as a consequence of):	•		υι						
	587	6 × 6			d										
) XC	Physician: The law requires that the death certifica this certificate has been signed by the attending phy ral director, page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	.55					23d.	Date of delive	ry	
	œ.	that the death cer ed by the attendir detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ♣No		ant at time of death	3 □Ectopic p 5 □ Other (s						Month	Day '	Year
	P.0	at the	Phys	9 Unknown				7			No. Did sobo		ontribute to th		donth?
	S,	ires the signed I be de	by	Sternal Del		Repaired		cause giv	en in Paπ I.	2	:39. Did toba 1 ☐ Yes		_	ably 4 ⊟l	
	Š	law requires as been sign 2 should be	etec	Sierral De	noence,	Repaire		-			4a. Was an	-	b. Were auto		- X-0.5
	Rec	he lav	dmo							-	autopsy	ed?	prior to co death?	npletion of c	ause of
	tal	iclan: Th certificate rector, pag	Be Co	25. Was case referred to medica					26. Place of	of Death (Che	Yes 2	-	1 🗆 Yes	2 NO	
	ίV	tending Physician: The laath. for: After this certificate ha	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 🔍	npatient 2 ER/Outpa	tient 3 D	OA Oth	er: 4 🗆 Nurs	sing Home	5 🗌 Residen	ce 6 □(Other (Specif	1)	
	o n	ing Pt After th	ino	27. Manner of Death 1 ■Natural 5 □ Pendir	28a. Date of (Mont	of Injury 28b. Tim th, <i>Day Year)</i> Injur		28c. Injun Wor			Describe how	injury occ	urred		
	sio		icati	2 Accident investing 3 Suicide 6 Could	gation	of laius. At home form	M etroet feete		Yes 2 □ No		ocation (Str	at and Nu	mber or Pur	i Pouta Num	har
					city or Town,		mber of ridiz	111001011011	001,						
	2/	Hospita 4 hours Funerel	Medical C		Examiner: On the ba	best of my knowledge, dasis of examination and/oner stated.									;)
		To the within 2 To the complet	Me	29b. Signature and title of certifie	(A			_	e number		290	d. Date sig	ned (Month,	Day, Year)	
				> 4/4/7/2.	HUL M.D.		1	238	357C)	J	anua	ry 17	200	4
		H		30. Name and address of person	who completed caus	e of death (Item 23a) (Ty Surfe 508	pe, Print)	Ralin	adom i	he I				21215	
		Sta	ite	31. Date filed (Month, Day, Year)	32. R	egistrar's Signature	~	~-·\VE	MOLE	ا ب	۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱	١٥٠٠	יייי	- 1-1	
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			1 = For State Registrer	State of Ma	ryland / Dep		t of H	ealth a	and Me	ental Hy	giene Reg. No.	2001	. 01016
			Decedent's Name (First, Middle, Last))					2	2. Date of Dea	ath		3. Time of Death
	Physici		Hazel Lee	Davis					-	Month January	7 16	2004	9:59 P M
	/Medio		4a. Fecility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of				County of Dea	
	Examin	iei	306 Mary Lou Ave					mie				Anne A	
2.4			5. Social Security Number 6. Se		(In yrs. last birthday			If Under:	24 Hrs. 8	Date of Birt	h		
	Funeral Director			M 200F	88 Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Da)			thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent							Sep. 9,	. 191	5 V1	rginia
	land		10a. State 10b. County		10c. City, Town or L	ocalion							10d. Inside City Limits
	Mar)	ō	Maryland Anne Aru	ndel	Glen Bu	rnie							1 ☐ Yes 2∑ No
	the 28a	9	10e, Street and Number			10f. Zip	Code				10a. Citiz	en of What Co	ountry?
	with a or	ā	310 Ferndale Road				2106	1				ed Sta	Ť
	ours after death with the Marylan rel', or Iteme 23a or 28a-f show Examiner must be notified at	Funeral Directo		12. Was Decedent E	ver in U.S. 13				gin? (Speci	ify Yes or No-		4. Race - Ame	
	ler d	Ę	1 Never Married 2 Married	Armed Forces?	,	If Yes, spec	ify Cuba	n, Mexican	, Puerto Ri	ify Yes or No- ican, etc.)		Black, Whi	
36	I', or	by	3 □ Widowed 4 □ Divorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:		1 Yes	XXN0	Specify:				Specify: W	hite
10a. State 10b. County Maryland Anne Arundel Glen Burnie 10e. Street and Number 310 Ferndale Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Married 12 Married 14 Married 15 Married 15 Married 15 Married 16 Married 16 Married 17 Married 17 Married 18 Married 19 Mar								16b. Kin	d of Business	Industry			
5	in 7	Completed	(Specify only highest grad		life.	B kind of wor DO NOT us	k done d	luring most	t of working	7			,
7	with ene.	E	Elementary/Secondary (0-12)	College (1-4or 5+		Iomemal	kor				0	wn Hom	•
	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the M		17. Father's Name (First, Middle, Last)		L	Ouche	ZCI	18. Mothe	er's Name (First, Middle,			Е
an	d be antai	Be c	Franklin Elmo Kib	ler				Dora	Tee	Barton	,		
\geq	and Mental and Mental Is marked of surnatic eve	ဥ	19a. Informant's Name/Relationship (T)		10h Mail	ing Address	(Street a					Town, State,	Zin Coda)
Maryland	d2s than 7 is i	Ì	Anne Hallinan - Da			Mary			_				land 21061
	nit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. orfant: If flem 27 is marked other than "natur injury or other treumatic event, the Madical B.		20a. Method of Disposition	~	20b. Place of Disp			710 С11	Dai			ation - City or	
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Baltimore,	Department of Important; If Important; If Important; If Imp injury or Imp		' 4 ☐ Donation 5 ☐ Other (Specify)		Meadowri								Maryland
39	Depar Depar Impor Impor		21. Signature of Funeral Service Licens	00	Ĝ	ary L	d Addres Ka	s of Facilit u£man	y Fune	ral Ho	me A	t MMP.	, Inc. yland 21075
ш	40 E E G		11. 190		7	250 W	ashi	ngton	Blvd	Elk	ridg	e, Mar	yland 21075
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	lications that caused t ne cause on each line	he death. Do not er	nter the mode	e of dying	, such as	cardiac or i	respiratory an	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Λ	450) n	Sici	l	/		cho	77		Onset and Death
F 18	/Medical		resulling in death)	Due to (or as a	consequence of):			A					
	Examiner		Commentation that the distance		Coonc	deg	a	nce	LUC	750	CVD	2	
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	te be executed ysician and le burial-transit	Examiner	triat militated events	c.	011	No	L	Tr	DUCI	ace	1	1	
o,	an ar	Ex	resulting in death) Last	Due to (or as a	consequence of):								
760,	<u> </u>	cai	(d									
68	leath certificate attending phy I for use as the	ledi											
Вох	andin use	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		Oc:					2	3d. Date of de	livery
Ω.	deat e att	icia	in the past 12 menths?	4☐Pregnant at t		□Ectopic pro □ Other (spo						Month	Day Year
0	that the de led by the a detached f	Physician/Med	9 ☐ Unknown	9□ Unknown									
٦,	The law requires that the death certifica lite has been signed by the atlending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions co.	ntributing to death but	not resulting in the	underlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
5	quire n sig ald b	D D								1 ☐ Y	′es 2 🗆	No 3 P	obably 4 Unknown
00	w require been si should I	iet								24a. Was a	an	24b. Were au	utopsy findings available
Records,	The law cate has page 2 s	Completed								autop	med?	death?	completion of cause of
		Ö	25. Was case referred to medical	-				00 Pr	-1 01 /	1 Yes		1 🗆 Yes	2 No
Ξ		o B	examiner?	Hospital:	t 2 ER/Outpatie		Othe	r		Check only of		Y	daughter's
of	Phys r this rai d		27. Mann of Death	28a. Date of Injury			^	4 🔲 Nu		d. Describe h			city)residence
on	ding f h. After funer	ţ	1 Accident 5 Pending investigation	(Month, Day	Year) Injury	м	Bc. Injury Work	? ′es 2 □!			, ,		
2	Attending ir death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, st	reet factory			_	f. Location (S	itreet and	Number or Ri	ural Route Number,
Division	or A after Dire	Certification;	4 Homicide determined	building, etc.	(Specify)		, 0,,,,,			City or Tow	m, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	747710010710111001,
	pitel ours eral filled		29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge dos	th occurred	at the tem	o data and	d place ap	d due to the a			- I alatad
	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medical Exami	ner: On the basis of e	examination and/or in	nvestigation,	in my op	inion, deat	th occurred	al the time, o	date and p	place, and due	to the cause(s)
	ithin o the	Me	29b. Signature and title of certifier			29c	License	number		- 2	29d. Date	signed (Mont	h, Dev. Year)
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•	b		20 Normand		nth (ltom 2001) T	Deign		, -1	> U	10	11	1/-	9
	*		30. Name and address of person who co		RITZ HIE		La Carl	Cr	2010	11124 10	1 m	210	1/ / -
	Sta	to		32 Registrar		1796	7	90	6/0 12		1 11	200	, , ,
	Sta Registr		31. Date filed (Month, Day, Year)	4 Been	. A. A	sell !							

			Please Type or Print in Black in		
			101	partment of Health and Men	tal Hygiene
			Registrar	ertificate of Death	Reg. No C U U 4 U 1 U 1
	Phy	sician	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 3. Time of Death
	/M	edical	JAMES		ANOT 2004 19=06 M
	Exa	miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death In Ance on the second of the second o
	Funo	rol	UPPER CHESAPEAKE MEDICAL CE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	v) If Under 1 Year If Under 24 Hrs. 8. [
	Fune Direct		213-32-4461 1/5-M 2 F 6 7 Yrs.	Months Days Hours Min.	Date of Birth 9. Birthplace (State or Foreign Country) O 9 450 VLNN VVVVVV
	land land		10a. State 10b County 10c City, Town or	Location	10d. Inside City Limits
	he Mary 8a-fsh	Director	MD Baltimore Perry	Hall	1 □ Yes 2 🗖 No
	1215-0036 within 72 hours after death with the Maryland ene. then 'neturel', or Items 23a or 28a-1 show witch the restrict of the state	al Dir	10e. Street and Number 9418 Bell hall DR.	10f. Zip Code	10g. Citizen of What Country?
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 14. Race - American Indian, n, etc.) Black, White, etc.
٩	36 safte	Y.	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	1 ☐ Yes 2 ☒ No Specify:	Specify: White
0	5-0036 72 hours at neturel; or	d by	3 Widowed 4 Divorced Year or Dates: 54-5	to the Mark Committee of the Committee o	
~ •	15 in 72	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given life.	edent's Usual Occupation or kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
6	2121 ed within ygiene.	E E	Elementary/Secondary (0-12) College (1-4or 5+)	IDAMO OGOIAT	MSURANCE
~	Hyg other	BeC	17. Father's Name (First, Middle, Last)	18 Mother's Name (Fir	st, Middle, Maiden Sumame)
	land be denta	ToB	806 Patrick Wunn	MARY	Lelancer
	Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "n env injury or other reumatic event."			iling Address (Street and Number or Rural Ro	ute Number, City or Town, State, Zip Code)
	and 2 auth n 27 i		Margaret A Wann-wife 941	8 Bellhall K. B.	altemore MD 21236
7	Baltimore, permit. Pages 1 a popular of Heal mportent: If item monton of the pages 1 a		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	position (Name of Pate Pate)	20c. Location - City or Town, State
0	Pag ment ent:		'4 □Donation 5 □Other (Specify)	Valley Mem 200	7 TIMONIUM, MD
1	Salt emit. epart nport	9	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	& Funeral Chapel
-	m 40 5 e	a	MUSIUS Sells 18	5800 Harrord Rd 1	5alfimore MD/21234
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		Interval Between
	Physici /Medic		Immediate Cause (Final disease or condition resulting in death)	ncepholopath.	4
	Examin		Due to (or as a consequence of):		
		<u>-</u>	Sequentially list conditions, flany, leading to immediate b. Due to (or as a consequence of).	BOLVS ENG	02000
	uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	BOLVS ENG	621.60 RECE
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M			d		
Z	certificate oding physise as the	Je Je	IE ECANA E.		
5	BOX ath centification or use	ar/	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy	23d. Date of delivery
1	_ e e e	Physiclan/Medl		Other (specify)	Month Day Year
#	ords, P.O requires that the een signed by the	Æ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
2	of Vital Records, Physician: The law requires to this certificate has been signeral director, page 2 should be c	dby	CHLOME ATMAL FIBRILLATIO		1 ☐ Yes 2 👺No 3 ☐ Probably 4 ☐ Unknown
-	K requ	Completed	COPD		24a. Was an 24b. Were autopsy findings available
Ŋ	Rec The taw te has b	d m		· · · · · · · · · · · · · · · · · · ·	autopsy performed? performed? performed? performed?
65	tal in: T ifficate or, pa	ပို	Is charmic cardiomy ope H	26. Place of Death (Ch	I Yes 2 No 1 Yes 2 No
2	ysicia	To Be	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	0.1	5 ☐ Residence 6 ☐ Other (Specify)
12		Ę	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d.	Describe how injury occurred
1 (isior ittendin death. ctor: Afr	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No 1 -	a ristaurent
٠	Division or Attending after death. Director: Atte	Certification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
7 7	ris af	ق	CHUCK CHEES	EB029EN 50	ELAIR SPKUY BELAIR
2	Hosp 14 hou	edical	29a. Certifier (Check only Check only Check only 1☐ Certifying Physicien: To the best of my knowledge, dea Check only 2☐ Medicel Exeminer: On the basis of examination and/or in	ath occurred at the time, date and place, and o investigation, in my opinion, death occurred at	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
1	Division To the Hospitel or Attention Within 24 hours after death To the Funeral Director:	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	⊢≯⊨ŏ ⊦		& garrish of Am	0 2155	
	111	4	30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)	JAJ 16, 2004
	101	1			M MD 21093
		State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0	
	Reg	istrar	JAN 2 0 2004 Am &	south)	

1. December Training Project Name of Prof. (Asset), Case) South Committee Sout		ATIVICE	100	1 - For State Registrar	State of M		d / Depa		of H	ealth a	and N			21	04	010) [(
Medical Feature Featur		Physic	ion	Decedent's Name (First, Middle, La.	st)									v	Year	3. Time of D	eath
Prince P													y 17	, 20	04	15:05	М
Social Security Number of Decident 213-30-3751	1	Exami	ner)					of Death				of Death		
Use of Berlington December		Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. Ia	st birthday)	If Under	1 Year	If Under		8. Date of Bir			9. Birthr	place (State or F	Foreign
To County To C				213-30-3731	□м 27Д F	70	Yrs.	Months	Days	Hours	Min.	FEB 20	, 19	33	Mar	y Land	
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Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker Down Home		Maryl 1 sho	ior	Maryland N/A		1											
Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker Down Home		r 28a	rec	10e. Street and Number				10f. Zip (Code				10g. Cit	izen of W	hat Cour		
Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker Down Home		th with	aiD	925 Binney Street				212	224				USA				
Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker Down Home		t dee	Iner	11. Marital Status	Armed Forces	?	13.	Was Decede	ent of His	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-				
Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker Down Home	36	rs afte	y F	4.4	If Yes, Give												
Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker Down Home	9	2 hou	ed	15. Decedent's Ed	lucation		16a, Deced	dent's Usual	Occupa	tion			16b Ki	nd of Bu	siness/In		
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Physician / Medical Examiner Physician / Medical Examiner Medical	E G	Page nent c int: If iry or		1 ☐ Burial 2 【XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State ()						1-18	-04	Balt	imon	e. N	4D	
23a. Part I. Flore the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease) or continuous and peach of the cause o	Balt	permit. Departr Imports any inju		1 some	900 M		22	Name and Cremat 199 Fr	Address 10n	SOC1	ety Road	of MD.	Inc.				
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Second Color Section		/Medical Examiner	xaminer	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	b. Due to (or as	s a conseque	ence of):	Cardio	vaso	ular	Dis	ease			Bast		
25. Was case referred to medical examiner? 1	190	te be e ysiciar ie burië	caiE														
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25. Was case referred to medical examiner? 1	.O. Box	the death ce by the attendi ached for use	hysician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1□Live birth 4□Pregnant a	2 Fetal d	leath 3 🗌						2			,	ır
25. Was case referred to medical examiner? 1	ds, Р	signed to be det	by	Part II. Other significant conditions of	ontributing to death t	out not result	ing in the un	iderlying cau	use giver	in Part I.							
25. Was case referred to medical examiner? 1	cor	w requ	iete				3					· · · · ·					
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Work? Accident Solution So	₹	sicial	00	examiner?	Hospital:	2005	D/O	0 000	Other		-					-	
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e c g a d and manner stated.	N	he Hospital n 24 hours a he Funeral pletely filled	edical (Check only 212 Medical Exam	iner: On the basis o	of examinatio	edge, death n and/or inv	occurred at estigation, in	the time n my opir	, date and nion, death	place, a	and due to the co	ause(s)	and mani place, ar	ner as sta id due to	ated. the cause(s)	
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		To t To tl	Σ	29b. Signature and title of certifier	/	0		29c. l	License	number		2	29d. Date	signed	(Month, L	Day, Year)	
) Zaluille T 0.C.M.E. January 18, 2004	•	1		· Zalvill	18 X	7			0	.C.M.	E.		Janu	ary	18,	2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 248/42114 Aug 111 Penn Street, Baltimore, Maryland 21201		9		30. Name and address of person who can also the second sec	completed cause of c	death (Item 2			Str	eet,	Bal	timore,	Mar	ylan	d 21	201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				31. Date filed (Month, Day, Year)			- 4	00 -									
DHMH 17 Rev 1/2001 JAN 2 0 2004	DHr		27	IAN 2 0 200	A P		A. C.	331									

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev Year **Physician** Margaret Mary Dohler 17, 2004 4c. County of Deeth 1:10 AM January, /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Millennium at Marley Neck Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. lest birthday) **Funeral** Deys Hours Months 1 □ M 2 □ F Yrs. 82 20, 1921 Director 213-16-4021 Usuel Residence of Decedent Maryland filed within 72 hours efter daath with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 7822 Overhill Road 21060 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married ð 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 pernit. Peges 1 and 2 should be filed Department of Heelth end Mental Hyg Important: If Item 27 ie marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Richard Greb Annie Meyberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Vincent J. Dohler/Son 7822 Overhill Road Glen Burnie, MD 21060 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-19-04 Metro Crematory Inc. Baltimore, MD 21. Signature of Funeral Service Licens 22. Name and Address of Fecility
Cremation Society of MD. Thomas Gregor Inc. 299 Frederick Road Baltimore, 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Accident Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit or Attending Physician: The law raquiras that the deeth certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 5 Pending investigation 1 X Naturel s after deeth. 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Atter within 24 hours after der 7 To the Funeral Director completaly filled in by th 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number D-40521 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 325 Kaspital Drive

Registrar DHMH 16 Rev 6/95

State

DA. O CHANEY

31. Date filed (Month, Day, Year)

Dohler

Margaret

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

	Physici	an	State Registrar 1. Decedent's Name (First, Middle, La. EDNA M.		Certificate of Deat	2. Date of De Month	Day	Year 3. Time of Death
	/Medic	Acres in	4a. Facility Name (If not institution, give		4b. City, Town, or Location	JANUARY	Y 15 4c. County	2004 1930 M
	Examir	er	WILLIAM HILL MANO		EASTON	TO Boath		
17 N	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birt)		ar 24 Hrs. 8 Date of Bi	rth	Birthplace (State or Foreign Country)
	Director		210 03 3300	□M 2√2 F 95 Y	Yrs. Mortins Days Hours	June 0	1 1908	Maryland
	Maryland s-f show	tor	Usual Residence of Decedent 10a. State	undel Co. Pasa	or Location adena			10d. Inside City Limits 1 ☐ Yes 2 X No
3	un with the 23a or 28a ust be nut	Funeral Director	10e. Street and Number 1826 Chesapeake	Road	10f. Zip Code 21122		10g. Citizen of V	-
0500	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Indoportential field in 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Modical Extendred Face in the Fourthed at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Microwed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specify		5- 14. Rac Blac Specify	e - American Indian, sk, White, etc. :: white
ָה ה	natu nicel	Completed	15. Decedent's Ed (Specify only highest gra	lucation 16a. I	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost of working	16b. Kind of Bu	usiness/Industry
y ;	snould be filed within and Mental Hygiene. B marked other than " umatic event, the Max	шрі	Elementary/Secondary (0-12)	College (1-4or 5+)	Accountant		Amoco (); 1
2	Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)			her's Name (First, Middle	1	
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, maryiand z iz io-uuso	and 2 sho salth and h 27 Is me er traume		19a. Informant's Name/Relationship (Mailing Address (Street and Num. 1435 Island Clul			
altimore,	of He If item or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3	cemetery	Disposition (Name of y, crematory or other place)	Date		City or Town, State
	ntment rtent:		*4 □ Donation 5 □ Other (Specify	// Mt. Carm	nel U.M. church cem.		Pasaden	a, Md.
ם ם	Deparent Dep		21. Signature of Funeral Service Licen	500	McCully-Poly 3204 Mounta	vniak Funera	1 Home j	o.A. Md. 21122
	hysician /Medical Examiner	Į.	sneeds to condition resulting in death) Sequentially list conditions, if any, leading to immediate		gerenal	1 4		Approximate Interval Between Onset and Death
7	ansit	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events		.,,			
00100,	physician and sthe burial-transit	ā	resulting in death) Last	Due to (or as a consequence of d.	f):			
J. DOX G	ires triat trie death behinbate signed by the attending phys I be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Dat Mor	e of delivery hth Day Year
	d d t	by P	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part	I. 23e. Did t	14	
אירו (פטור)	equies in section of the could be could	ted b				1 🗆 '	Yes 2 No	nbute to the cause of death? 3 Probably 4 Dunknown
The learned and and a state of	ing law requires in cate has been signed; page 2 should be categories.	Completed				24a. Was	an 24b. V	
Vital necolus, r.v.	certificate has been signe irector, page 2 should be o	Be Completed	25. Was case referred to medical examiner?	Hospital:	26. Plac	24a. Was autor performed to the control of the cont	an 24b. V osy p rmed? d 2 No 1	3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 25 No
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		•	1 - For Amend Item# 29d Registrar	State of Ma per FH,G82	ryland/	Departme 2004 gap Certific	ent of H	lealth a <i>Death</i>	nd Me	ental Hyg	giene Reg. No. 2	004	01021
	Physici /Medic	an	1. Decedent's Name (First, Middle, Las	"UPUY						Month ANVAS	Day)	Year 2004	3. Time of Death
	Examin		4a. Fecility Name (If not institution, give NORTAWEST 1308)		NTER			LUST				nty of Death	RE.
R	Funeral Director		5. Social Security Number 6. Se 11	7. Ag	e (In yrs. last i	Mont	hs Days	If Under 2 Hours	Min.	Date of Birth Month Day	1902	9. Births Cour	olace (State or Foreign otry) OH
	nyland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location			· · · · · · · · · · · · · · · · · · ·			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Mar 728a-11	Funeral Director	MD BALT 10e. Street and Number	IMORE		BALTIMO 10f.	JKE Zip Code				10g. Citizen o	of What Cour	
	23a o	rai D	3612 SYLVAN DRIV					2120					U.S.A.
920	iges 1 and 2 should be filed within 72 hours effer death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinational be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:			scedent of H specify Cuba s 2 💢 No	lispanic Orig an, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	Spec	lace - Americ Ilack, White, cify:	
21215-0036	I within 72 he iene. r than "natu	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12			5a. Decedent's L (Give kind of life. DO NO HOMEMA k	work done	during most	of working	,		Business/In	dustry
Maryland 2	should be filed with nd Mental Hygiene s marked other than umatic event, The L	To Be C	17. Father's Name (First, Middle, Last) GUS			CARLSON	and the state of t	H.	ILDA	First, Middle,		MA	rtson
Mar	d 2 sho th and t7 is ma traum		19a. Informant's Name/Relationship (7	урв, Print) AUGHTER		9b. Mailing Addi 3612 SYL							Code)
85	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☒		20b. Place	of Disposition (Name of		Da	-	20c. Locatio		own, State
Baltimore	Per Jan Per Ja	i	*4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen)	LAKE	PARK CE		Y ss of Facility	1/5/2		YOUNGS		
Ba	permit. Departimporti		Detroll-	With	<u></u>					LEVIN OAD -			MD 21208
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each li	the death. D			TALL			rest,		Approximate Interval Between Onset and Death
y 8.	/Medical Examiner	er	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Underlying	b	a consequence					. , , , , , , , , , , , , , , , , , , ,			
,160,	eath certificate be executed attending physicien and for use as the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequent	ce of):							
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal dea	ath 3 □Ectop	ic pregnancy r (specify) _	/			1	Date of delive	ery Day Year
	quires that n signed b ud be dete	d by Pl	Part II. Other significant conditions of	ANCER		g in the underlyii	ng cause giv	ren in Part I.			obacco use co ⁄es 2 □ No		he cause of death? pably 4 XUnknown
l Records,	The law requir ate has been si page 2 should	complete	HYPERTENSI	06%	-			<u> </u>		24a. Was autop perfor	med?	b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings available mpletion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case relerred to medical examiner?	Hospital: X			DOA Oth	205		Check only o	100	24 (2	
on of	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju		Outpatient 3 b. Time of Injury M	28c. Injui	4 1401	28	e 5 Resid			у)
Division of Vital	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At home ic. (Specify)	, farm, street, fa	ctory, office		28	Bl. Location (S City or Tow		mber or Run	al Route Number,
	ne Hospil 24 hour ne Funer detely fills	edical		ysician: To the best niner: On the basis of and manner st	of examination					d at the time,	date and place	e, and due t	o the cause(s)
	To the To the Comp	X	29b. Signature and rule of certifier	PHY	SICIA	7		278		P	UNAUK	4 3	Day, Year) 2004
_			30. Name and address of person who AVVERAINALLI	m It	ARISH		540	TH W	257 LD (175100	15817 PO(7P. 1	19 8 1133
	Sta Regist	ate rar	31. Date liled (Month, Ray Year)	32. Regist	rar's Signature	and I							

		-	- For State Registrar Amend Item#23ap	State of Maryland / erPHYG828 2/18/04					Reg. No.	2004	01022
	Physicia /Medic		Decedent's Name (First, Middle, Last)	Lawrence Vladi	imer D	udar		2. Date of De Month	Day	2004	
\$4.	Examin Funeral Director	er	4a. Facility Name (If not institution, give stress of the facility Number of Security Number of Sex 152	11 1	birthday)	4b. City, Town, o	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Yeer)	9. Birth	10RE uplace (State or Foreign untry)
3			Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	ition		0000	2011		10d. Inside City Limits
	28a-f sh	Director	Maryland Ba	ltimore		10f. Zip Code	Essex		10a Citiza	en of What Cou	1 Yes 2 No
	23a or 2	al Dir	1142 East Rivers	side Avenue			21221		Un	ited S	tates
920	if, or Itama	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1.☑Yes 2□No If Yes, Give Korean Year or Dates:		as Decedent of H Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify:	
500-612	be filed within 2 nous after bean with the waryand tal Hygiene. do other then "natural", or Itama 23a or 28a-f show event, it is Medical Examinar must be notified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation 16 completed) College (1-4or 5+)	(Give kil		during most of work d)	ing		d of Business/l	
ם פ	other of the design of the des	Be Col	17. Father's Name (First, Middle, Last)	1 Years	Admi	.nistrat	18. Mother's Nam	e (First, Middle		cial Sed Gumame)	curity
yland	should be rised nd Mental Hygi marked other imatic event, i	ToE	Anton Dudar	o Original	Ob Mailine	Address /Street	Marie	Olejni		Toum State 7	in Code)
Ma	nd 2 sr alth and 27 is m ir traum		19a. Informant's Name/Relationship (Typ Mrs. Donna J. Duda				Riverside		-		land 21221
O	ges 1 a t of Hea if itam or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	moval from State ceme	etery, crema	tion (Name of atory or other pla	ce)	Date		ation - City or 1	
Бащто	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		* 4 □ Donation 5 □ Other (Specify) 21. Size ature 17 meral Service Lice	According to the state of	22.1	Name and Addre	Corp. 1/1 ess of Facility k Funeral			•	Maryland
מ	Deparation of the policy of th		23a. Part1. Enter the disease, or complic	rations that caused the death. C	79	922 Wise	Ave. Du	ındalk,	Mary		21222 Approximate
	nysician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	MYCCARD A MYCCARD A Due to (or as a onsequence	INFA		HURE	-			Interval Between Onset and Death
grou,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
BOX C	death certify e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3 □E	Ectopic pregnand Other (specify) _	у		23	3d. Date of deli Month	very Day Year
rds, P.	law requires that the des as been signed by the a 2 should be detached fo	by	Part II. Other significant conditions conf	ributing to death but not resulting	ng in the und	derlying cause gr	ven in Part I.		tobacco us		the cause of death?
Ì	The ate h page	Completed						24a. Was auto perfe 1 \(\text{Yes}		24b. Were autoprior to death?	topsy findings available completion of cause of
VItal	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1⊠Ínpatient 2□ER/	/Outpatient	3□ DOA Ot	28. Place of Deather: 4 Nursing Ho	th (Check only)		Other (Spec	cify)
Division of	ath. r: After thi		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		b. Time of Injury	28c. Inju		28d. Describe			
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or To	wn, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Examin	ician: To the best of my knowled lef: On the basis of examination and manner stated.	dge, death of and/or inve	occurred at the t estigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Sala			se number			signed (Month	
	^		30. Name and address of person who col	mpleted cause of death (Item 23	Ba) (Type, P	rint)	5 0000			7-200	
	10		DR Jeffery Swet	TT 9000 FRAN	Klin	SqUARE	DR. BA	1Timo	RE,	Md .	21237
8	Sta Regist	ate rar	31. Date filed (Month, Ddy, Year)	32. Registrar's Signature	dans	2					

DHMH 17 Rev 1/2001

LAWRENCE

ORIGINAL

						d / Depa		lealth an	d Mental Hyg	giene Reg. No. 2001	01024
			Decedent's Name (First, Middle, Last)						2. Date of Dea		3. Time of Death
	Physici	an		Nancy	Gora	ldine	Daybrow	ski	Month	y 15,2004	3:30 A ^M
,	/Medic		4a. Facility Name (If not institution, give stre		QC,1, a	Taile	4b. City, Town, or			4c. County of Dee	
	Examin	er	2517 Hillford Driv					kville			more Co.
-			5. Social Security Number 6. Sex		(In ure I	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birtl	0.0:	
	Funeral Director			267 F	9	Yrs.	Months Days		Min. (Month, Day	1924 Wes	thplace (State or Foreign puntry) t Virginia
	and and		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Aaryl sho	ō									1 ☐ Yes 2% No
	the N	Director	Maryland Baltim 10e. Street and Number	ore			10f. Zip Code	Ca	arney	10g. Citizen of What Co	nunta/2
	with por						Tot. Zip Code	0100			
	ath 23	Funeral	2517 Hillford Driv			1		2123		United S	
	er de	une		Was Decedent Ev Armed Forces?		5. 13. 1	Mas Decedent of Hi f Yes, specify Cuba	ispanic Origin in, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
36	ori	by F		1 ☐ Yes 2 ☐ No If Yes, Give	0		I□Yes 25kNo	Specify:		Specify:	
ë	hours after death with the Maryland tural, or Items 23e or 28e-f show II Examinational be notified at	d b	3 XWidowed 4 □ Divorced	Year or Dates:							White
,	72 net	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)		(Give	lent's Usual Occupa kind of work done of	during most of	working	16b. Kind of Business Baltimore	Industry County
2	within 72 ene. than *nat	mp	Elementary/Secondary (0-12)	College (1-4or 5+	-)		OO NOT use retired	•		Public Li	_
N	filed v Hygie other t		12 Years			Libra	arian Aid	_			4
ב	tal H d ot	Be	17. Father's Name (First, Middle, Last) Edward Weir Wharto	n. Sr.					Name (First, Middle,		
<u>8</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show atmatic avent, the Modell Examiner countries to multiled at	70	Edward World Wilder					Maı	ry Ola Spe	nce	
Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type,							r, City or Town, State,	
≥ .	1 and 2 Health a tsm 27 is		Mrs. Rebecca Gorsu	ch (Daug	-	·		rd Dri		, Maryland	21234
Ze	of He		20a. Method of Disposition	aval from State	20b. Pl	ace of Dispo metery, cren	sition (Name of natory or other place	e)	Date	20c. Location - City or	Town, State
Baltimore,	Page nent nt: if		1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Gar	dems	of Faith	Cem 1	/19/2004	Rosedale	, Maryland
	arth inju		21. Signature of Juneral Service Licensee		In	// 22	Name and Addres	s of Facility			_
ñ	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr 2002.		> (hallly	Kal		7	022 11:00	7/370 1	M MIChau	Dundalk, aryland 21	
			23a. Part1, Enter the disease, or complicate shock, or heart failure. List only one complicate shock.	ions that caused t	he death	. Do not ent	or the mode of dying	g, such as car	diac or respiratory an	est,	Approximate
	W 6.		shock, or heart failure. List only one of Immediate Cause (Final	ause on each line	a.'	_	10.148	-			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	MEPIH	110		TILU PE				T HENDU
	Examiner			Due to (or as a	consequ	ence of):	BLEAT	(1.	" M		VELAC
1		_	Sequentially list conditions, b. —	Due to (or as a	CODSEGU	ence of):	DICE 47/	SAN	766.		9577
	bed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	240 10 (01 43 2	oonsoqu	onco 01).					
	and and	Kan	that initiated events c resulting in death) Last	Due to (or as a	CODEAGU	ence of):					
760,	be executed sician and burial-transit			Due to (or as a	Consequ	erice or).					
	death certificate be executed e attending physician and od for use as the burial-transit	dical	d						-		
68	ing p	Physician/Med	IF FEMALE:								
Rox	th ce tend	an/	23b. Was decedent pregnant 23c.	If yes, outcome of 1 Live birth 2			Ectopic pregnancy			23d. Date of de Month	
	he al	sici	in the past 12 months?	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of de	ath 5	Other (specify)			MOIIII	Day Year
J.	at the by ti	Ϋ́	9 Unknown								
	The law requires that the de ate has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions contrib	outing to death but	not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	w require been sig should t		DIABETES						_ 1 TY	es 2/211√10 3 □ Pi	robably 4 Unknown
Š	aw re	Completed	ATRIAL F	BHILL	477	IN			24a. Was a	n 24b. Were at	utopsy findings available
Ĭ	Physician: The lav this certificate has al director, page 2 a	E							autop:	med2 death?	completion of cause of
g	iffical or, p	O	25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only or		ZLI NO
5	sicia cer irect	8	examiner?	oital:	, 201	ER/Outpatien	Othe		1/	ence 6 Other (Spe	aif.)
Ö	Phy r this ral d	1: 70		28a. Date of Injury	,	28b. Time of				ow injury occurred	city)
o	ding h. Afte fune	io	1 Natural 5 ☐ Pending	(Month, Day	Year)	Injury	28c. Injury Work	<br Yes 2 □ No		,,	
S	deat deat tor:	ica	3 Suicide 6 Could not be	28e. Place of Injur	ry - At hou	me farm etr			28f Location /S	treet and Number or Re	ural Pouta Number
Division of	il or Attending P after death. I Director: After t I in by the funera	Certification:	4 Homicide determined	building, etc.	(Specify)	set, factory, diffice		City or Tow		arai noute ivamber,
	pital ours erai		29a. Certifier 1 Certifying Physici	en: To the boot of	f my kn ou	dodes deeth			loop and during the		
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edical	(Check only 2 Medical Examiner one)	On the basis of e	examın <i>a</i> tı	ion and/or inv	estigation, in my of	pinion, death o	occurred at the time, of	late and place, and due	to the cause(s)
	thin the	Mec	29b. Signature and title of certifier	ang mamor state	-		29c. License	number	2	9d. Date signed (Mont	h. Dav. Year)
	F ₹ F 8		· C (hn)				0	277	30	1/16/0	
			700					- ' ' '		1101-1	
	1		30. Name and address of person who comp	6 7. 9 A	ath (Item	23a) (Type,	TIT.	SALT,	MONE.	40 212	04
<u> </u>	10							77-16	/		,
	Sta Registr		JAN 2 2004	32. Registrar	J. Jigilat	10004					

			1 - For State Registrar	State of I	Marylar		artment <i>rtificate</i>			nd M	_	giene Reg. No.	/ 1111		025
	Physici /Medic		Decedent's Name (First, Middle, Las Ronald	′	Р.		Davi	s			2. Date of De. Month 01/10	Day	/ Yea		of Death
ı	Examin		4a. Facility Name (If not institution, give 3225 Westdale Cou		er)			own, or L	ocation of	Death			County of De Char	ath	
	Funeral Director		217 40 0001	x 7. M 2□F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bird (Month, Da 05/11/	h y, Year) 1948		irthplace (State Country) ashing t	
Maryland	-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Charles	3		ity, Town or Lo Valdorf	cation							10d. Inside	City Limits
with the	3a or 28e at be noti	i Director	10e. Street and Number 3225 Westdale Co	urt			10f. Zip (Code 20601				10g. Citi	izen of What (Country?	
5-0036 72 hours after death with the Maryland	"natural", or items 23a or 28e-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 図 類vorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ss? DNo		Was Decede f Yes, speci I Pes 2		panic Origi , Mexican, Specify:	n? (Spe Puerto í	cify Yes or No Rican, etc.)			nerican Indian, nite, etc. White	
- c	Hygiene. kther then "natura ent, Ine Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation		(Give	lent's Usual kind of work DO NOT use Binter	k done du e retired)	ion ring most o	of workin	ng .		nd of Busines	•	
yland ould be file	ental Hyg ked othe Ic event,	To Be Co	17. Father's Name (First, Middle, Last) William Charles D					1	Mary	Ε.	(First, Middle, Espina	Maiden	Sumame)		
	r Health and Mitem 27 is mar other traumat		Mary E. Davis / M			1		- 11			Route Numbe Timbers			, /	
Pages	0		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			Place of Dispo cemetery, cren SUTTEC t	sition (Name natory or oth Cion C	e of her place) Cemet	ery C	o 1/1	4/2004	20c. Lo	cation - City o	r Town, State Mary Lar	
Balt Permit.	Department Importent: I any injury o		21. Signature Inneral Service Licent	les		- 6	5160 0	xon	Hill	Road	1 Oxon	Hill	Funera , Mary	1 Home land 20	PA 0745
	ysician : Medical		23a. Part1 Enfer the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	sed the dear n line. as a consec	domin	4		such as ca			rest,		Approxima Interval Be Onset and	etween
68760, ifficate be executed W	physician and it is the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or	as a consec	quanna of):									
. Box 6	the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	2 Fete	eldeath 3 🗆	Ectopic pre					2	23d. Date of de Month	elivery Day	Year
ecords, P.O	sign d be	by	Part II. Other significant conditions co	ntributing to deat	h but not res	sulting in the ur	nderlying car	use given	in Part I.		23e. Did to	-		to the cause of	
E P	has je 2	Completed								_	24a. Was a autop perfor		prior to death?	utopsy findings completion of s 2 No	available cause of
Of Vita Physicien:	iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ∐ Inpa	atient 2□] ER/Outpatient	3 ☐ DOA	Other			<i>(Check only or</i> e 5 ∑ √Resid		☐Other (Spe	acify)	
VISION O	tor: After thi	ertification:	27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28 M	c. Injury a Work? 1 ⊟ Ye		2	3d. Describe h				
DIVISIO To the Hospital or Attendi	winin z4 nours after de To the Funeral Directo completely filled in by th	Certific	3 Suicide 6 Could not be 4 Homicide determined	building,	etc. (Specia					1	City or Tow	n, State)		lural Route Nur	nber,
e Hosp	e Funer letely fill	edical	29a. Certifier (Check only one) Certifying Phy	rsician: To the be iner: On the basis and manner	s of examina	owledge, death ation and/or inv	occurred at estigation, i	t the time, n my opin	date and paid death	olace, a occurre	nd due to the o d at the time, o	ause(s) a late and	and manner a place, and du	s stated. e to the cause(s)
Toth	To th comp	Me	29b. Signature and title of certifier.	Jeult	ed n	10		License n	0 1		2	9d. Date	signed (Mon	th, Dey, Year)	
1)		30. Name and address of person who o		atro	2411	sile	chael Cf	A. 1		herwood	_			
É	Sta Registr		31. Date filed (Month, Day, Year)		stray's Signa		Ana	et le							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** Year January 3, 9:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3008 Linwood Avenue Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye August 7, 9. Birthplace (State or Foreign Country) **Funeral** 218-68-7168 1 □ M 2/□ F 70 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow in then "natural", or items 23e or 28e-f ahove the Medical Exeminer must be notified at Baltimore Mary land Parkville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 Linwood Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 XX Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: δ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental H is marked Francesco Luppino Concetta Marretta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Osage Road Hunt Valley Maryland 21030 permit. Peges 1 and 2.
Department of Health ar
Important: If item 27 is
any injury or other trau Salvatore DiFatta/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/8/04 Dulaney Valley Memorial Gardens Timonium Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 once hus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) , una tive Pnysician Ylen /Medical Due to (or as a consequence of): Examiner -ar unica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): the burialby the attending physicien Physician/Medical the death certificate use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Dav 5 Other (specify) Yes 2 No o ۵. law requires that signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, pe Completed 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 ☑ Ninknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2.2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient ToF 2**X**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2. ♣R/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ö Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical the 29b. Signature and title of certifier 29c. License number å 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05/6 Drive 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0.6 2004 Registrar

			For State Registrar	State of Maryland / D	epartment of Health Certificate of Death		ene 2004	01027
			Decedent's Name (First, Middle, Last,			2. Date of Death		3. Time of Death
	Physici: /Medic		Richard	ELLIOTT,	JR	JAN 1	Pay LOOY	10 55 A M
	Examin	-	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location	of Death	4c. County of Death	
			2110 Town Hill	RD APT. B	Parkville		BALTIN	will
	Funeral Director		5. Social Security Number 6. Se. 3214 - 12 - 3266	6.000	hday) ff Under 1 Year If Under 1 Year Months Days Hours		(ear) 9. Birtho	lace (State or Foreign htry)
	Pu ,		Usual Residence of Decedent	10c. City, Town		,	1	0d. Inside City Limits
	anylar •hov	<u>_</u>	10a. State 10b. County DALTIA		0			1 ☐ Yes 2 ☑ Ño
	Ne M	Director	MD BALTIN	rope	PARKVILLE 10f. Zip Code	100	g. Citizen of What Cour	
	with Ber	흡		ill Rs. Appr	0 1 2 V	103	U-5.	
	heath me 23	Funeral	210 Town K	12, Was Decedent Ever in U.S.	13. Was Decedent of Hispanic O	origin? (Specify Yes or No-	14. Race - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show important: If tier 27 is marked other than "natural", or items 20 or 28a-f show eny injury or other traumatic event, Ita Medical Examinar must be notified at once.		1 ☐ Never Married 2 ☐ Married 3 ☐ ₩7dowed 4 ☐ Divorced	Armed Forces? 1 Pres 2 No TYes, Give Year or Dates:	If Yes, specify Cuban, Mexica		Black, White,	hite.
215-0036	2 hou	Completed by	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupation	16	6b. Kind of Business/Inc	
7	within 7 ene. than "n	pie	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)			0.0
21	ygien Ygien I. De	Con	12+4	NIn	Computer Of			CUE (Ty
Maryland	ld be fill ental Hy kad oth Ic even	To Be	17 Father's Name (First, Middle, Last) Richard Elliot	T SR		her's Name (First, Middle, Ma Len Peel	aiden Surname)	
ary	shou ind M ind M umat	-	19a. Informant's Name/Relationship (T)	rpe, Print) 19b.	Mailing Address (Street and Numi	ber or Rural Route Number, (City or Town, State, Zip	Code)
	and 2		Dorothy BRIET	en Bach 2	110 Townhill R	D. APT.B. B	Alto. No 2	1234
ore	of He of He fiten roth		20a. Method of Disposition 1 ☐ ourial 2 ☐ Cremation 3 ☐ F	cemeter	Disposition (Name of crematory or other place)	Date 20	oc. Location - City or To	wn, State
Ë	Pag ment ant: I ury o		'4 □Donation 5 □Other (Specify)				alto, Ms.	
Baltimore,	permit. Page Department of Important: If eny injury of		21. Schatur, of Funeral Service Licens	Still	22. Name and Address of Fact HARTICY MILLE 7527 harford	RD. Batto.	M 21234	CHTD.
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	na causa on each line	ot enter the mode of dying, such a	is cardiac or respiratory arres	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Myoco	endial in	farction		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of		1		
4	LXammer	ē	Sequentially list conditions, if any, feading to immediate	b	<i>\$</i>).			
	led Isit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	11).			
_,	al-trai	Examin	that initiated events resulting in death) Last	c	f):			
8760,	cate be executed physician and the burial-transit	dical		d				
89	tificat ig phy as th	4						5.00
Вох	death certifu e attending I ad for use as	N/UE	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death	3 ☐Ectopic pregnancy		23d. Date of delive	•
O. E	that the death certifued by the attending popularies as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year
P.O.	res that the igned by be detact	Ph	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part	t I. 23e. Did toba	cco use contribute to the	ne cause of death?
Records,	·= % D	ed by	<i>_</i>	Stema		1 Tes	2 □ No 3 □ Prob	ably 4 Punknown
သ	aw Is b	Completed				24a. Was an autopsy		psy findings available mpletion of cause of
_	Th ate pag	Con				perfórme 1 ☐ Yes 2 ☐	ed? death? PNo 1 ☐ Yes	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Jan-itali.		ce of Death (Check only one)		
*	G ii.	J.	TO THE ZEING	Hospital: 1 Inpatient 2 EP/Out	patient 3 DOA Other: 4 N	Nursing Home 5 Residen		y)
LC.	Jing F	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. T (Month, Day Yeer) In	ime of 28c. Injury at vijury Work? M 1 ☐ Yes 2 [28d. Describe how	injury occurred	
Division	Attended death ctor:	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, far		28f. Location (Stre	et and Number or Rura	I Route Number,
Ö	al or / s after al Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town,	State)	
7/	To the Hospital or Attending Ph within Z4 hours alter death. To the Funeral Director: After completely filled in by the funeral	edical (29a. Certifier 1 ✓ Certifying Phy (Check only one)	sician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date a Vor investigation, in my opinion, de	and place, and due to the cau eath occurred at the time, date	ise(s) and manner as si e and place, and due to	ated. the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	1. 12. NI	29c. License number	7 7 7	d. Date signed (Month,	Dey, Year)
	i		beryl 1	secur 11	1)12	126	1/20/04	<i>f</i>
	0		30. Name and address of person who c	ompleted cause of death (Item 23a) (2701 N.Clara	rles 8t. Bo	Huou a	nd 21204
	Sta Registi	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1. Specie			

			1 – For State Registrar	State of Ma	aryland /		rtment tificate			ınd M		giene Reg. No.	200	01028
	Physici		1. Decedent's Name (First, Middle, La WILLIAM THOMAS	*	₹.						2. Date of Dea Month JANUAR	Day	Year 2004	3. Time of Death 4 9:25 A M
	/Medio Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City, T	own, or	Location o	f Death	OTE TOTE C		County of Dea	
			VA MARYLAND HEAD 5. Social Security Number 6. S		STEM e (In yrs. last l	hirthday)	PE If Under 1		POINT		8. Date of Birt	h	CECIL	ath-lane (Chata as Essive
	Funeral Director			M 2□F	90	Yrs.		Days	Hours	Min.	(Month, Da)	y, Year)	PEN	rthplace (State or Foreign Ountry) NA •
	land bw		Usual Residence of Decedent 10a. State 10b, County		10c. City, To	wn or Loc	ation							10d. Inside City Limits
	the Marylan r 28a-f ehow	ctor	MD. N/A		ВА	LTIM	ORE							1 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f ehow f reust be neithind at	al Director	10e. Street and Number 1317 IDYLEWOOD	RD.			10f. Zip (Code 1208				_	on of What C	ountry?
920		by Fur	11. Marital Status 1 □ Never Married 2√√ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☑ I If Yes, Give Year or Dates:			/as Decede Yes, speci		panic Orig , Mexican, Specify:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	i i	I. Race - Am Black, Whi Specify: Bl	•
Maryland 21215-0036	72	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			(Give k life. D	ent's Usual and of work ONOT use	done di retired)	tion uring most	of workin	g		d of Business	
.z pc	tygi Ther nt, I	Be Co	17. Father's Name (First, Middle, Last,			1	LABOR		18. Mother	r's Name	(First, Middle,		LEHEM umame)	STEEL
ylaı	nd 2 should be f Ith and Mental h 27 Is marked of r treumatic eve	To	ENOCH W. EDISO								DARKU			
	as 1 and 2 st of Health and item 27 Is n r other treun		19a. Informant's Name/Relationship (CATHERINE E. E		:)	1317	IDYL	EWOO	D RD.	BAL	Route Numbe	MAR	YLAND	Zip Code) 21208
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Dother (Specification)	y)	GARRI	tery, cremi SON F	atory or oth	ne <i>r pla</i> ce L VE	, TERAN			Owing	ation - City or s Mill	s. Marvland
Balt	permit. Pag Department Important: h eny injury o		21. Signature of uneral Service Licer	O THE	Brew	BNE <u>最</u> 172	Name and 21 – 27	Address	of Facility	PHIL E ST	LIPS FU	JNERA [MORE	L HOME	L, P.A. LAND 21217
	Physician /Medical		23a. Part . Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SEPS		o not enter	r the mode	of dying	, such as c	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death 5 DAYS
ı	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. DIABE										10 YEARS
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	e of):								
9	artificate ing physi e as the l	Ø -	IF FEMALE:	- V										
.O. Box	requires that the death certific een signed by the attending p nould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deal		ctopic pre Other (spe					23	d. Date of de Month	livery Day Year
rds, P	tw requires that s been signed k s should be det	ρ	Part II. Other significant conditions o	ontributing to death be	ut not resulting	in the und	derlying ca	use giver	in Part I.			bacco use es 2 🛚		o the cause of death?
of Vital Records,	The law ate has b page 2 st	Completed	-1								24a. Was a autop: perfor 1 🗆 Yes	n sy med? 2 <u>X</u> No	24b. Were as prior to death?	utopsy findings available completion of cause of
Vita	Physicien: Th this certificate al director, pag	00	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2□ER/C	Sutpotiont	3□ DOA	Other			(Check only or		70	
n of		on: To	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur	y 28b.	. Time of Injury		c. Injury			e 5 🗌 Resid 3d. Describe h			city)
Division	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home,		М	1 🗆 Y	s 2□N		Bf. Location (S City or Tow		Number or Ri	ural Route Number,
<u>ا</u>	Hospital 4 hours a Funeral i	edical Cer	(Check only 2 Medical Exer	ysician: To the best oniner: On the basis of	examination a	ge, death o	occurred at	t the time	, date and	place, ar	nd due to the c	ause(s) ar	nd manner as	s stated. to the cause(s)
_ ′	To the within 2 To the Complet		one) 29b. Signature and title of certifier	and menner sta	ted.			License						h, Day, Year)
	í		1 Vanu	1 ar	vas 1	M) 1	D389	50			Janu	ary 18	, 2004
Ì	H		30. Name and address of person who					DD 6			DDV 503	NIE	MD 010	.00
	Sta	٠.	MANUEL RAMOS, M. 31. Date filed (Month, Day, Year)	32. Registra	Signature	neal'	LH CA	KE S	xolei∖	I, PE	RRY POI	MT,	MD 219	UZ
	Registr	ar	JAN Z	0 2004 > 1	Buch.	N. Com	1	AP -						

DHMH 17 Rev 1/2001

NAME KNOWN TO PHYSICIAN: EDISON, WILLIAM THOMAS,

		1 - State Registrar AMEND ITEM 22 1. Decedent's Name (First, Middle, Last	t)	/ 1/21							ate of Deat				3. Time of D
sici: edic		Spero			Fot	ies	>			1	onth NVALL	Day		ar 4	18:28
	er	4a. Facility Name (If not institution, give		10	- /	4b. City	, Town, or			1		4c.	County of D	Death	
		0011110	iview Medi		enter	I Killada	Dalt er 1 Year	7 MO	r 24 Hrs.	10.5	to of Diale			Diat. I	(Oh. h
		5. Social Security Number 6. Se 236–14–9715	ox 7.Ag XIM 2□F	e (In yrs. I 84	ast birthday, Yrs.	Months		Hours	Min.	(M	ate of Birth Ionth, Day,	Year)	9.	Countr	ace (State or I
		Usual Residence of Decedent		04		1				Oct	. 31,	, 19	19 We	St \	Virgin:
		10a. State 10b. County		10c. City	, Town or L	ocation								10	d. Inside City
	cto	Maryland			Balt	imore	<u> </u>								1½ Yes 2
	Directo	10e. Street and Number				10f. Z	ip Code				1	l0g. Citi	zen of What	t Countr	ry?
	Funerai	438 Elrino Stree		5i. 11	0 12) No D	212		nimin 2 /Co	nanifu V	an ar Na		<u>mited</u>		
	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ i		5. 13.	If Yes, sp	edent of Hi ecify Cuba	n, Mexica	ingin (S)	o Rican,	es or No-		Black, W		
7.7	ý	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	10		1 Tes	2 x No	Specify	<i>/</i> :				Specify:	Whi	ite
7	tea	15. Decedent's Ed			16a. Dece	edent's Us	ual Occupa	ation	et of wor	tina		16b. Kii	nd of Busine	ess/Indu	ustry
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1	Be	17. Father's Name (First, Middle, Last)									t, Middle, I		Sumame)		
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		19a. Informant's Name/Relationship (T											r Town, Stat		
		Helen Proakis - Si 20a. Method of Disposition	Ister	20b. P	ace of Disp		io Sti ame of	reet	Bal	L C.LIII Date			yland cation - City		
		tX Burial 2 ☐ Cremation 3 ☐ I		C	emetery, cre Lawn	matory or	other place	e)	1/10	9/04					Marylar
		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Funer, Service Licer.		Joan				s of Faci						C, I	aryrai
		Burn	The Stoot	MIC	1142 F	BRADLE	Y-ASHT	ON-MA	THEW	S FUN	VERAL I	HOME,	,INC. 1D 2122	2	
		23a: Part V Enter the disease, or comp	plications that caused	the death	n. Do not en								111 2122	,	Approximate Interval Betwe
		shock, or heart failure. List only of Immediate Cause (Final	one cause on each in	ne.	1 0										Onset and De
١		disease or condition			Local	aml	2004	(Str	Alco	1			-	Onset and De
ı		resulting in death)	a. Due to (or as	a consequ	uence of):	ard	702	_(;	str	oka	2)			5	day
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			1 - For State Registrar	State of Maryland		artment of H		R	eg. No.	2004	01030
-	Physici /Media Examir	cal	Decedent's Name (First, Middle, Last) Alice 4a. Facility Name (If not institution, give si	Steuart Fenn		4b. City, Town, or	Location of Dea	2. Date of Dea Month JAN	Day 15,	Year 2004 ounty of Deeth	3. Time of Death 9:50 a M
万变	Funeral Director		523-07-7173			Rock If Under 1 Year Months Days	(VIIIe If Under 24 Hr Hours Mir		Year) 1904	Montgor 9. Birthol Count Colo	lace (State or Foreign try)
	ith the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number	ery	, Town or Lo	Germanto		1		n of What Coun	0d. Inside City Limits 1 ☐ Yes 🏂 No try?
036	be filed within 72 hours after death with the Maryland at Hygiene. A set Hygiene of the than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Madral Examiner man be multied at	by Funerai	11301 Neelsville 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Church Road 12. Was Decedent Ever in U.S. Armed Forces? 1			876 ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	14	USA Race - America Black, White, e	
d 21215-0036	filed within 72 ho Hygiene. othar than "natur ant, the Mourcal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		(Give life.	dent's Usual Occupi kind of work done of DO NOT use retired	furing most of w	orking ame (First, Middle,	Acco	of Business/Ind	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked othar than other traumatic event, the M	To Be	George R. Steuart 19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street a	Alio	ce Bannist	er		Code)
a,	Pages 1 and 2 nent of Health int: If Item 27 i		James Fenn/son 20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	ace of Dispo metery, cren	lawlings I sition (Name of natory or other place matory,	θ)		20c. Loca	0 20877 tion - City or Tov 1timore	
Balt	permit. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service License Dawn F MCDO 23a. Part1. Enter the disease, or complice	y IC March		99 Freder	rick Roa	of Maryl d Baltin	and,	Inc.	
760,	Physician personned with the principle of the principle o	licai Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	e cause on each line.	ence of):		g, 300.1 a 30.0 a				Interval Between Onset and Death
	at the death certifica by the attending phateched for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 5 No 9 ☐ Unknown	3c. II yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			230	d. Date of deliver	y Day Year
Records, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cont	3	lting in the ur	nderlying cause give	en in Part I.	23e. Did tot			e cause of death?
Y	The ate h page	e Completed	25. Was case referred to medical				00 80	24a. Was a autops perform	ned? LZNo	24b. Were autop prior to com death? 1 ☐ Yes 2	sy findings available apletion of cause of
ō	ng Phys fter this neral dii	To B	examiner?		R/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 Nursing	eath (Check only on Home 5 Reside 28d. Describe ho	nce 6		
	o Pire	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				28f. Location (St. City or Town	, State)		
Y	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier (Check only one) 29 Medical Examination one) 29b. Signature and title of certifier	ician: To the best of my know er: On the basis of examinati and manner stated.	on and/or inv	29c 1 icense	number	20	ad Date c	ioned (Month, D	av Voas
			30. Name and a press of person who con	mpleted cause of death (Item	23a) (Type,	DZ Print) GRO	8656	20AD R	TAN	WARY, I	6,2004 M020850
3 ,	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 2 0 2004	327 Registrar's Signatu	TLO STATES	all p				/	,

		•	For State Registrar		(State o	f Mary	land / I				ealth a		lental H	ygiene Reg. No	201	04	01	031
		J	1. Decedent's Nam	e (First, Middl	e, Last)									2. Date of D	Death Da	ıv	Year	3. Time	of Death
16×9	Physicia /Medic		ELLWOO	D NELS	ON F	CLBERI								Januar	y 19	, 200)4	2:50	AM
8	Examin		4a. Facility Name (i	f not institution	n, give str	eet and nur	mber)			4b. City,	Town, or	Location	of Death		40	. County o	of Death		
7			Greater						_		son	If Under	24 Hen	1		altir			
7.3	Funeral	i	5. Social Security N 219-20-9		6. Sex	M 2□F	7. Age (In	yrs. last bi	Yrs.	If Under Months		Hours	Min.	8. Date of B Month, D 9/2/19	Day Year				e or Foreign
3)	Director		Usual Residence o				7'	7					L	7/~/17	20		MAR	YLAND	
4	/land		10a. Slate	10b. County			10	c. City, Tow	n or Loc	ation									City Limits
3	Mar.	tor	MD	BALT	IMORE	£		PARK	VILL	E								1 🗆 Y	es 2 XNo
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+-	ltams	Funeral Director	11. Marital Status 1 ☐ Never Marr	o X M		Armed Fo	rces?	r in U.S.	13. W	Vas Dece Yes, spe	dent of Hi cify Cuba	ispanic Or n, Mexicai	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	No-		k, White,	can Indian, etc.	
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Maryland	s i and 2 should be filed within 72 hours after death w f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23e other traumatic event, It a Medical Exertit at traust						urne							TIMORE			33	, 0000)	
	1 an Heal tem 2		MARGARET 20a. Method of Dis	position				20b. Place o	of Dispos	FORR	ne of		-	Date TINORE	-		_	own, Slate	
JOH IOH	ages ant of it: If i		1 ☑ Burial 2 `4 ☐ Donation	☐ Cremation	3 ⊟Rei Specify)	moval from	State	MOREL		natory`or d MEM •			1/21	/2004	HI	LLEND	ALE.	, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health s important: If item 27 is any injury or other tra	1	21. Signature of F		-							ss of Facili		IE JOHN					P.A.
ä	Depa impo any ii	ķ,	fla	the	N. S	Hay	-	-	8	521	LOCH	RAVE				N, MD		1286	
	30 1 3 80		23a. Part1. Enter shock, or hea Immediate Cause	art failure. Lis	r complications	ations that of cause on e	aused the	death. Do	not ente	or the mod	de of dyin	g, such as	cardiac	or respiratory	arrest,	1		Approxim Interval E Onset an	Between
	Pnysician / /Medical Examiner		disease or condition resulting in death)	on	(a.	Due to	(or as	onsequence	of):	CON.	CUL	7	V CIE	1114	jun	4	-	120	atta
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	es that the deathigned by the atte	by Physician/Med	in the past 12	□No			nant at time			Other (s						Mon	th	Day	Year
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Division of Vital Records,			Part II, Other sign			nibuling to u		ocrasaking		idenying t						_	3 ☐ Proi		Unknown
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Ä	The I	EO												per 1 🗆 Yes	rformed?	de	eath?	2□ No	
ital	ician: 1 certifical rector, p	Bec	25. Was case refe	rred to medic									e of Dea	th (Check only	v one)				
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Ο̈́	after after Direct of in by	Certification:	4 Homicide	deten	mred	build	ing, etc. (5	- At home, f Specify)			,,			City or T	own, Stat	θ)			
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' /	the thin 2 the	Medical	one) 29b. Signature an	tive of tertifi	er /	and mar	ner stated	l.		29	c. Licens	e number			29d. Da	ate signed	(Month.	Day, Year	r)
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	111		30. Name and add	ress of person	n who con	npleted cau	se of death	h (Item 23a)	(Type,	Print)_	V	1	7/	/	-/	11/	10	-/	
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical Examiner

Funeral Director

Directo

Funeral

Completed by

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Physiclan/Medical

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Completed

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Certification:

Medical

State

Registrar

72 hours after death with the Maryland item 27 is markad othar than "natural", or Items 23a or 28a-f show othar traumatic event, the Madical Examinar must be notified at 1 and 2 should be filed within Health and Mental Hygiene.

Frank, Celia

Jahan Knowin as

Pnysician /Medical Examiner

5 Department of Important: If any injury or once.

for use as the burial-transit law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760 certificate has r death. Ictor: After this certifica by the funeral director, p

Hospital or Attending after death filled in by 24 hours a e Funeral I completely within 2 To the I

1 - For State Registrar Certificate of Death Reg. No 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2004 0135 AM FRANK CELIA Januar 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Baltmore Baltimore Hospital N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2 🙀 F 87 213-20-5065 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2 HIGHSTEPPER COURT #304 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No WHITE Specify: Specify: Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURER MENS' BELTS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL GALLANT ZENTZ FANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD B. FRANK / SON 14 RIVER OAKS CIRCLE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY: 1/16/2004 * 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yancreatic years cancer Due to (or as a consequence of): po tension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due fo or as a consequence of: (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4)Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year) January 15, 2004

srun. MUC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 2 0 2004

5 🗀 Pending

investigation

6 Could not be determined



DHMH 17 Rev 1/2001

H.

			1 - For State Registrar			Maryla	-	artmer rtificat		ealth and Death		Reg. No	2001			
	Physici /Medio Examir	cal								Location of Dea	2. Date of Month 1	1 1	Yeer 2004 County of Death	3. Time of Death 3:05 PM		
	Funeral Director		5. Social Security Nu 218–32–4! Usual Residence of	ical Cntr. Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. Min. Min. Min. 7/						Date of Birth, Month, Day, Year) //9/1935 Harfor 9. Birthplece (St. Country) Marylan						
,	ne Maryland 8a-f show	al Director	10a. State 10b. County MD Harford				Stree	t			10d. Inside City Limits 1 ☐ Yes 2 🌠 No					
	death with the ms 23a or 28a rhust be noti		10e. Street and Number 1129 Poplar Grove Road			d	10f. Zip Code 21154						tizen of What Cour USA	ntry?		
036	5 £ E	i by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	Armed For 1 ☐ Yes If Yes, Give	1 ☐ Yes 2 TvNo			dent of His city Cubar 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or I to Rican, etc.)	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White					
1605	within 72 hc ene. then netur	o Be Completed	15. Decedent's Education (Specify only highest grade complete) Elementary/Secondary (0-12) College			ad) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry				
	buld be filed wit Mental Hygiens arked other tha atic event, the		12 17. Father's Name (First, Middle, Last) James P. Deckman				Homemaker 18. Mother's Name (First, Middle, M Beulah Cox						Own Home taiden Sumame)			
Maryland	nd 2 shou lith and M 27 is mar		19a. Informant's Nat	,	(Type, Print) s/husban	đ					ural Route Num		or Town, State, Zip			
//i/loy Baltimore	Pages 1 a ent of Hea nt: If Item y or othe		20a. Method of Dispo 1 X Burial 2 ☐ 4 ☐ Donation	Cremation 3	☐Removal from S	tate	Place of Dispo cemetery, cre-	osition (Nai matory or o	me of other place)	Date 5/2004	20c. Lo	ocation - City or To	wn, State		
/// Baltir	permit. Pag Department Important: any injury o		21. Signature of Fun			11	1 12	2. Name ar	nd Address	of Facility			rlington St. Delta,			
#128082	cale be executed /Medical Examiner /Medical and street ithe burial-transit	dical Examiner	23a. Party: Enter the disease, or coepilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): CANGESTIVE FIBRILLATION Due to (or as a ponsequence of): CANGESTIVE HAWRE													
P.O. Box (the death certifical y the attending phy ached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 The past 12 months 1 T									23d. Date of delivery Month Day Year				
Records. P	strian: The law requires the certificate has been signed irrector, page 2 should be d	þ	CHRONIC RENAL INSUPPICIONAL. 10]Yes 21	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Hriknown					
Marri Vital Red		Completed	10	BET6	8 M	24a. W au pp 1 1 Ye					an 24b. Were autopsy findings available prior to completion of cause of death? 2 2 No 1 Yes 2 No					
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on of	ding Ph .r. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Da)			Injury , Day Yeer)	ry 28b. Time of 28c. Injury at 28 y Yeer) Injury Work?					28d. Describe how injury occurred				
Francis, Division	Hospital or Attending 4 hours after death. Funaral Director: After tely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju building, etc.			of Injury - At h g, etc. <i>(Speci</i>	M 1 ☐ Yes 2 ☐ No At home, farm, street, factory, office 28f. Location (Specify) City or Tov					(Street and	Street and Number or Rural Route Number, wn, State)			
F	To the Hospital within 24 hours. To the Funaral completely filled	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											ated. the cause(s)		
	To the comple	M	29b. Signature and t	A	- La	Lee	MD		License 2	6/9/		29d. Dat	te signed (Month, l	Dey, Year)		
	10		30. Name and addre	HA S1	RITHAR	of death (Ite	11/6 20	Print)	505	032812	DRIVE.	, Tol	USON, MO	021264		
	Sta Registr		J. Date med [Month	JAN 1	7 2004	ALC:	the A.	Alle	Ale I							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:41 P M NORMAN N. GERST, SR. 16 2004 January /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner 69 Cool Breeze Drive Baltimore County Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 M 2 □ F 218 14 0702 79 November 1 1924 | Baltimore Co., MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Machael Examinat: intal be nutified at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69 Cool Breeze Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ₩ Widowed 4 Divorced WII Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NAFinisher Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George J.B. Gerst Sophia Shure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 69 Cool Breeze Drive Norman N Gerst Jr (Son) Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery January 20 2004 Baltimore, Maryland 21 assanddfonerun Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1 No 24a. Was an page 2 autopsy performed 1 Yes 2 X10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Tes 2 100 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Datural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai

31. Date filed (Month, Day, Year) State Registrar JAN 2 0 2004

(Check only one)

29b. Signature and title of certifie

Fran

32, Registrar's Signature Mark!

and manner stated

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January **Physician** 2004 Josephine Patricia Guarnera 8:10 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🛛 F 1, 1942 212-40-2091 Feb. Director 61 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examinar must be notified at Yes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1605 Ramsay Street 21223 United States 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2√√2 No Specity: If Yes, Give Year or Dates: ģ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Kenneth Hammond Mary Josephine Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sh ment of Health and ant: If item 27 is m Arlene Curry - Daughter 1605 Ramsay Street Baltimore, Maryland 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State partment o. Important: If it. 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Balt. Wash. Crematory 1/20/04 Laurel, Maryland permit. Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Serviçe Licenses 100 Mzk. Hackman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Kars resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit Due to (or as a consequence of): physician a s the burial-t Box 68760 Physiclan/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death Year signed by the a d be detached for 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No of Vital 1 Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death Check on one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1) certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) 29b. Signature and little of Artifier 29c. License number 29d. Date signed (Month, Dey, Year) i mo 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto. Md 2120x 670 Bm(31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2004 Registrar

			For State Registrar	State of M	1arylan		artment of I		nd Ment	al Hygie	2.0	ΩL	01036	
		0	Decedent's Name (First, Middle,					2. Date of Death 3. Time of De						
	Physicia		James F	Richard	chard Gernhart					January 17,2004			1:53 A M	
	/Medic Examin		4a. Facility Name (If not institution,	give street and number				or Location of I	Death	4c. County of D				
			7834 Denton Road					ows Poi			Balti			
	Funeral			6. Sex 7. A 1 ☐ M 2 ☐ F		last birthday) Yrs.	If Under 1 Year Months Days		Min. (M	te of Birth lonth, Day, Ye			e (State or Foreign	
	Director		216 42 1501 Usual Residence of Decedent	X	59	115.			Ja	n. 31,	1944	Balto.	.,Maryland	
	land ow	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d.	Inside City Limits	
	Mary Feb		Maryland Baltimore Sparrows Point										1 ☐ Yes 2X No	
	I within 72 hours after death with the Maryland liene. Idea. Than "natural", or Items 23e or 28e-f show the Medical Examinational De notified at	Il Director	10e. Street and Number 7834 Denton Road		10f. Zip Code 21	219		10g.	10g. Citizen of What Country? USA					
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,	"nati		15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working	160	b. Kind of Bus	iness/indusi	try	
7	filed within Hygiene. other than "	шc	Elementary/Secondary (0-12)	College (1-4or	r 5+)					De	altimor			
7 0	Hyg Hyg Int,		17. Father's Name (First, Middle, L		Obe	rations :	s Name <i>(Fir</i> si		•					
Maryland 21215-0036	should be nd Mental marked c	To Be	Raymond W. Gernh	ıart Jr				Ruth	n V. Th	numa				
ary		-	19a. Informant's Name/Relationsh				ng Address (Stree							
	alth a		Carole Gernhart	(wife)		7834	Denton 1	Road Sp	parrows	Point	. Maryl	and 2	1219	
altimore,	es 1 and of Healt fitem 2 r other 1		20a. Method of Disposition	2 Demoual from Stat		Place of Dispo cemetery, crea	osition (Name of matory or other pla	ice)	Date	200	c. Location - C	ity or Town,	, State	
Ĕ	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		° ∣ Oa	k Lawn	Cemeter	y Janua	ary 21,	.04 Ba	altimor	e, Ma	ryland	
Balt	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service L	icersee			2. Name and Addr 407 01d 1		DI UZUZ		Funera			
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39	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcom	,									
Вох	ath co	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnand	у			23d. Date Mont	y Year					
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S,	signed be det	d by								1 🗆 Yes	☐ Yes 2☐ No 3☐ Probably 4☐ Unknown			
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Division of Vital	ysician: The is certificate his director, page	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
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/isi	Atter dea actor	ifica	3 ☐ Suicide 6 ☐ Could n		reet, factory, office		28f. Lo	28f. Location (Street and Number or Rural Route Number,						
ă	i ji ji ji	Certification:	4 Homicide building, etc. (Specify)								City or Town, State)			
1	Hospital 14 hours a Funeral I	a	29a. Certifier 1 Certifying	Physician: To the bes	st of my kno	owledge, deat	h occurred at the t	ime, date and	place, and du	e to the caus	e(s) and man	ner as state	d.	
	the Hone Hone Hone Ether Fundletel	edical	one)	xaminer: On the basis and manner	stated.	and/or in	V		- occurred at t					
	Vithi Com	Σ	29b. Signature and title of certified	to		7	29% Licen	se number	11	29d.	Date signed	(Month, Day	r, Year)	
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	V		30. Name and address of person v	vho completed cause of	f death (Iter	т 23а) (Турв,	Print) Mox	yland	Oncolo	By Tou	pzos	/		
	٢		John & Do.	205 75C	strar's Sgn	Ster 1	Drivo #	4303	Dus	00 /	71) E	2/20	4	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	N 2 0 2084	Silai S John	Cartain of	H STONE	a)						

		1 - For State Registrar	State of Maryl	•	artment of Heali		Hygiene	
Physic	ian	1. Decedent's Name (First, Middle, Las	•			2. Date o	f Death	3. fime of Death
/Medi Examir		JoAnne 4a. Facility Name (If not institution, give Franklin Squo	- 11 0	itol	4b. City, Town, or Local	Jonu tion of Death	4c. Cour Bo	2004 11:30 FM hty of Death
Funeral Director		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday) 3 Yrs.		nder 24 Hrs. 8. Date o urs Min. (Month Jan	f Birth Day, Year) 7 1931	9. Birthplace (State or Foreign Country) South Carolina
Maryland -f show livd at	tor	10a. State 10b. County Maryland Baltimore		. City, Town or Lo	ocation	***		10d. Inside City Limits 1 ☐ Yes 2 ☐ Yo
h with the 23a or 28e	Funeral Director	10e. Street and Number 155 Bladen Road			10f. Zip Code 21 221			of What Country? USA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any njury or other traumatic event. Its Marical Examinat he notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanie If Yes, specify Cuban, Me: 1 ☐ Yes 2 ▼No Spe	c Origin? (Specify Yes o xican, Puerto Rican, etc. ocify:		ace - American Indian, lack, White, etc. cify: White
altimore, Maryland 21215-0035 mil. Pages 1 and 2 should be tiled within 72 hours af partment of Health and Mental Hygiene. portent: If item 27 is marked other then "natural", or y njury or other traumatic event, the Madical Excu-	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de com <i>pleted)</i> College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) ayroll Clerk			Business/Industry
aryland S should be filed and Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Many L. Lee			C	Mother's Name (First, Mic Carnathia	Worthy	
Mar od 2 sho od 2 sho lth and 17 ls m 27 ls m		19a. Informant's Name/Relationship (7) Donald J. Gluth (h.			ng Address <i>(Street and N</i> o Bladen Road			
more, Pages 1 ar		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Other (Specify	Removal from State	b. Place of Dispo cemetery, crei	osition (Name of matory or other place) Crematory IN	Date	20c. Location	n - City or Town, State
permit. F Departm Importer any njur		21. Signature of Fune al Service Licens		2:	2. Name and Address of F	acility Bruzdzir	nski Fune	
Physician /Medical		23a. Part1 Effer the disease, or comsh. c., or heart failure. List only Immedia. Cause (Final disease or condition resulting in death)	lications that sused the cone cause on each line. a. Due to (or as a con		er the mode of dying, such	h as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death Ook 5
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wrequires that been signed be should be deta	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause given in P		Did tobacco use co. ☐ Yes 2☐ No	ntribute to the cause of death? 3 Probably 4 Unknown
DIVISION OT VITAI HECORDS, I or Attending Physician: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed					a	utopsy erformed?	. Were autopsy findings available prior to completion of cause of death? 1 \$\sumsymbol{\text{Yes}}\$ 2 \$\sumsymbol{\text{No}}\$ No
VIII sician certifi	o Be	25. Was case referred to medical examiner? 1 🗆 Yes 2 🗹 No	Hospital: Inpatient	2 🗆 ER/Outpatier	Other	Place of Death (Check of	The state of the s	45 (0 5)
On Or ding Phy th. : After this s funeral d	 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	1 3 00A 4	_	ibe how injury occu	
UNISION OF VITA To the heaptitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		on (Street and Num Town, State)	nber or Rural Route Number,
To the Hespitel or Amitin 24 hours after To the Funeral Director Completely filled in b	edical	29a. Certifier Check only one) Certifying Phylogen Certifyin	rsician: To the best of my iner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	n occurred at the time, dat vestigation, in my opinion,	e and place, and due to death occurred at the tir	the cause(s) and n me, date and place	nanner as stated. , and due to the cause(s)
To the within 2 To the complex	Ž	29b. Signature and title of certifier Handu Six	on And		Rescu		29d. Date sign	ed (Month, Day, Year)
6		30. Name and address of person who Pr. Horv, na er Aroro	ompleted cause of death (Item 23a) (Type, In Say		30-Itimore	m) 2	1237
Sta Regist		31. Date filed (Month, Day, Year)	0 2004 Registrar's S	ignature /	Appende			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #30 PER DVR G827 1/20/04 JH Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia F. Goldsborough January 13, 2004 9:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Alice B. Tawes Nursing Home Crisfield Somerset Hours Min. 8. Date of Birth (Month, Day, Year) Oct 12, 1919 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days 84 217-42-6049 **Director** Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23s or 28s-1 show any linury or other treumatic event, the Medical Examiner must be restlined at another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Somerset **Funeral Director** Crisfield 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Hall Hgwy 21817 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced Specify: white Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) caregiver child care 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Franklin Betts ဥ Ronnie Catherine Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmira Ford/daughter 4018 Jacksonville Road Crisfield, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Pervice Licensee Rould S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Di rector Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): signed by the a d be detached f Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yee 2 ☐ Xfo 3 ☐ Probably 4 ☐ Unknown DIABETES Completed by certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2X No 1 Tes 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 24 hours efter death.
 Funeral Director: After this certifica funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 Yes 2 No ţ, 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760, within 2 To the

> State Registrar

JAN 2 0 2004

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D 48098

29d. Date signed (Month, Day, Year)

04

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:20AM January 17, 2004 Evelyn Minerva Gentry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A 3020 Elgin Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Feb. 90 Director 215-32-3005 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show 1 ¥Yes 2 □ No N/ABaltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3020 Elgin Avenue 21216 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the New Jingy event and Jing 8th Self Employed Domestic 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Taylor Mamie Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Taylor - Son 2503 Queen Anne Rd. Balto., MD 21216 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Balto. Co., MD Park 1/22/04 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 2501 Gwynns Falls pkwy. Balto., MD 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in death). Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No

9 Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dalv. Year) 29b. Signature and title of contifier 29c. License number ated cause of death (Item 23a) (Type, Print) 30. Name and address of person wh

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

at I DR

Signature

OF

2004

32. Registrar

			For State Registrar	State of Maryla		artment of H			ene . No. 2	
	Physici /Medic		1. Decedent's Name (First, Middle, Last Caroline Lon	g Gladsto	ne			2. Date of Death Month	Day Zear	
	Examin Funeral Director		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday) 19 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y DEC 14,	4c. County of Dea 9. Bir 1904 Man	th the feather of Foreign suntry) Tyland
	D	J.	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo			DEC 14;	1704 [Rd]	10d. Inside City Limits 1 □ Yes 2 ☒ No
	h with the N 23e or 28e-f st Le notitie	Funeral Director	Maryland Baltimor 10e. Street and Number 709 Maiden Choice			10f. Zip Code 21228			p. Citizen of What C	ountry?
036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23e or 28e-f show avent, the Medical Evertimer and Le notified at	þ	11. Marital Status 1 Never Married 2 Married 3 TWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Y <i>e</i> s or No- Rican, <i>e</i> tc.)	14. Race - Am Black, Whi Specify:	
21215-0036	e filed within 72 ho al Hygiene. I other than "natur vsnt, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life. Homem	_	ation during most of worki d)	ng	ob. Kind of Business Own Home	/Industry
Q	should be filed nd Mental Hygin markad other imatic avent, L	0	17. Father's Name (First, Middle, Last) Aaron W. Long				18. Mother's Name	Frank		
re, Mar	is 1 and 2 sh of Health and itam 27 is ir other traum		19a. Informant's Name/Relationship (7. Eugene A. Gladsto	one/Son	734	Manning S Sition (Name of matory or other place)		Philadelp	-	19106
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic as <u>once</u> .		1 Burial 2 Cremation 3 Control of the Control of the Control of Control of the Control of Control o) Nemovarirom State	letro Cr	ematory]	[nc. 1-20]		Baltimore nc. more, MD	21228
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Vital	Physicien: The I this certificate ha ral director, page	To Be Con	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	! □ ER/Outpatie	nt 3□ DOA Oth		(Check only one)	d? death? 1 Yes	
Division of	ath. rr: After	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	t home, farm, st	M 1□	Yes 2 □ No		et and Number or R	ural Route Number,
NO	To tha Hospitel or Atte within 24 hours after de To tha Funeral Directo completely filled in by tt		29a. Certifier 1 Certifying Ph	building, etc. (Spenysician: To the best of my hiner: On the basis of examples	knowledge, deat				se(s) and manner a	
,	To tha within 2 To tha complet	Medical	one) 29b. Signature and title of certifier	and manner stated.	5	29c. Licens	7009		Date signed (Mon	
	Sta Registi		30- Name and address of person who of the control o	ne, 711	Maid	0 1	ioice L	ane, ?	nomitted	19,2004 e,MD21228

	ı	For State Registrar	otato or marytar			of Health and <i>of Death</i>	ivientai n	Reg. No. 20	14 0104
Physicia /Medica Examine	n al	1. Decedent's Name (First, Middle, Last) Elizabeth Ann 4a. Facility Name (If not institution, give s Upper Chesapeake	treet and number)		4b. City, To	own, or Location of Dea	2. Date of l Month Janua	Day Ye	Death
Funeral Director			7. Age (In yrs.	last birthday) 77 Yrs.	If Under 1 Months I	Year If Under 24 Hi Days Hours Min	n. (Month,		Birthplace (State or Foreign Country) lassachusetts
the Maryland r 28a-f show	irector	Usual Residence of Decedent 10a. State 10b. County	Bel	ty.Town or Lo	10f. Zip C	ode		10g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 💢 No at Country?
ter death vitems 23s	<u>a</u>	205 Idlewild Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	t #1C 2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		2101 Was Deceder If Yes, specify 1 □ Yes 25	nt of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or ento Rican, etc.)	USA No- 14. Race - Black, V Specify:	American Indian, White, etc. White
d within 72 hours at jiene. Ir than "natural", or than the Madical Evant	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual (Occupation done during most of w	rorking	16b. Kind of Busin	ess/Industry
	To Be	17. Father's Name (First, Middle, Last) Eugene LaGarde 19a. Informant's Name/Relationship (Typ.	эө, Print)	19b. Maili	ng Address (S	Emma k	King	fle, Maiden Sumame) nber, City or Town, Sta	ite, Zip Code)
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trea	-	Kevin Perkins/Nep 20a. Method of Disposition 1 Burial 2 ©Cremation 3 GR 4 Donation 5 Other (Specify)	emoval from State	Place of Dispo cemetery, crea	osition (Name matory or othe	1	Abingdo Date -19-04	on, MD 210 20c. Location - Cit Baltimor	y or Town, State
permit. F Departme Importar any injur		21. Signature of European Service License Thomas Grego		22	2. Name and Cremati 299 Fre	Address of Facility on Society ederick Roa	of MD,	Inc. timore, MD	
rnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a conseq	etui	local	abstro			Interval Between Onset and Death
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oital or Attending Physics after death. real Diractor: After this liled in by the funeral death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy) 			City or 1	rown, State)	or Rural Route Number,
To the Hospital within 24 hours of To the Funeral completely filled	edici		ician: To the best of my knoter: On the basis of examination and manner stated.		vestigation, ir	imy opinion, death oc	curred at the tim		due to the cause(s)
State Registra	e	30. Name and address of person who appears of the hard	2 OS MA 32 Registrar's Signa	NU	1	0036715		eAKE 1	ned. Cta

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001

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			1. Decedent's Name (First, Middle, La	ist)					2. Date of I			Time of Death
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	/Medic Examin		4a Facility Name (If not institution, give					4b. City, Town	, or Location of De			
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	F		5. Social Security Number 6. 5		(In yrs. last bir			Glen Bi If Under 24	Hrs. 8. Date of E Min. (Month, I	irth Anne	Arunde	(State or Foreign
	Funeral Director			1□M 2\ F		Yrs. Month	ns Days	Hours	Min. (Month, i	C 1000		
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	tand		10a. State 10b. County		10c. City, Town	n or Location					10d. ln	nside City Limits
	dary	ö	Maryland Anne Aru	ındel	Glen	Burnie					1	☐Yes 2 ☐ No
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	with o	ā		4014								
	ath 23	ara.	102 Crain Highway	_	una in II C		1061	lionanio Origin	2 (Specify Vec or I	United S	American In	dian
	ar de	5	11. Marital Status	12. Was Decedent Ender Armed Forces?		If Yes, s	pecify Cub	an, Mexican, F	i? (Specify Yes or I Puerto Rican, etc.)		White, etc.	Carear I,
20	afte S	by Funeral Director	1 Never Married 2 Married	1 Yes 2 DNG	0	1 ☐ Yes	25 No	Specify:		Specify:	Whit	e
8	Je in	P	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		<u> </u>				101 16-1 16		
ζ	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23s or 28s-f show ent, the Medical Examiner must be not the dist	Be Completed	15. Decedent's E (Specify only highest gro		16a.	Decedent's U	work done	during most of	f working	16b. Kind of Busin	ess/industry	,
21215-0020	igh e di	<u>a</u>	Elementary/Secondary (0-12)	College (1-4or 5+	+)	life. DO NOT		u)				
	ygie ygie yerti	S	9	0		homema	aker	10 14-11-1	Name of Print Address	home		
2	al H al H	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd	le, Maiden Sumame)		
<u>s</u>	Men	2	Harry Duncan Horn	er				Estel	l Stewar	t		
Maryland	and and		19a. Informant's Name/Relationship	Type, Print)	19b	. Mailing Addr	ess (Street	and Number o	or Rural Route Nun	nber, City or Town, Sta	ite, Zip Code	e)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haaith and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Madical Examinar must be notified at other.		Bonita Cage - dau	lahter	86	90 Cast	tlemi	ll Circ	cle. Whit	e Marsch,	Marvla	and 21236
ē	S 1 g f Ha oth		20a. Method of Disposition	E(1),=1=8_	20b. Place of	Disposition (/	Vame of	ce)	Date	20c. Location - Cit	y or Town, S	State
٤	Pages nent of I ant: If Ite ury or o	i	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special						1/20/0/	Baltimor	ao Ma	arelend
Baltimore,	arten Property	ŀ	21. Signature of Funeral Service Lice		Dayvie	22. Name	and Addre	ss of Facility	Hubbard	Funeral Ho	e, Ma	ryrand
Ba	Depa Impo any I		1 / Jan 11 /	2:111								
			Mul g.	X4 UC						timore, Ma		
			23a. Part1. Enter the diseas of shock, or heart failure. List only	plications that caused to be cause on each line	the death. Do r e.	not enter the m	ode of dyir	ng, such as ca	rdiac or respiratory	arrest,	Inter	roximate rval Between et and Death
	Physician										Ons	et and Death
ď	/Medical Examiner		Immediate Cause (Final disease or condition	CONG	ESTIVE	. H.	EARI	FAI	LURE		F	
ā			resulting in death)	4.	Due to (or as a							
-	D .=	edicai Examiner									ì	
	cute nd rans	E	Sequentially list conditions,	Ε	Due to (or as a	consequence	of):					
ó	an a line	ш	if any, leading to immediate cause. Enter Underlying								i I	
68760,	te be	Ca	Cause (Disease or injury that initiated events	c	ue to (or as a o	consequence of	of):				-	
	es that the death certificate be executed igned by the ettending physician and be detached for use as the burial-transit	8	resulting in death) Last								İ	
ŏ	ndin use	Ž		d								
Bo	satte d for	Physician	Part II. Other significant conditions of	contribution to death but	t not resulting in	the underlyin	a cause aix	en in Part I	23b. Di	d tobacco use contri	bute to the	cause of death?
P.O.	tha y	lys		on the batting to down but			g occord g				☐ Probably	
₫.	that bed b								''			140
ds,	requires that the death been signed by the atter should be detached for u	d b							24a. W	as an autopsy 2	4b. Were a	utopsy findings
Ö	v require been signature	ete								rformed?	complet	e prior to tion of cause
ĕ	The law ate has t page 2 s	idir									of death	1?
=	The gate	Completed							10	1 Yes 2 X No	1 🗆 Yes	2 □ No
=======================================	Physician: r this certific aral director,	Be	25. Was case referred to medical examiner?						Death (Check onl			
Division of Vital Record	yslc is ce	္ရ	1 ☐ Yes 2 💢 No	Hospital: 1 1 Inpatien	nt 2 ER/Ou	tpatient 3	DOA Oth	ner: 4□ Nursi	ing Home 5□Re	sidence 6 DOther	(Specify)	
0	g Pt ter th	Ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		Time of njury	28c. Injui Wo	ryat rk?	28d. Describ	e how injury occurred		
ō	Attending or death. • ctor: After by the fune	at	2 Accident investigation			М		Yes 2 □ No				
N S	Atte or de by th	월	3 Suicide 6 Could not be determined	28e. Placa of Injur building, etc.	ry - At home, fa	rm, street, fac	tory, office			(Street and Number of own, State)	or Rural Rou	ite Number,
Ö	after after Direct of in b	Certification:	401101110100	building, etc.	(Бреспу)				0.0, 0.1	, 5.0.0,		
	splta hours nere y fille			hysician: To the best of								
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Example)	miner: On the basis of e and manner state		d/or investigat	ion, in my o	pinion, death	occurred at the tim	e, date and place, and	due to the	cause(s)
	omp	₹ E	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (A	Nonth, Day,	Year)
	⊢≯⊢ö		De la la la companya de la companya	ssahun	MB		500	(597	3	man so	1 14	2003
	/		- N							1011001120	-/ /0/	
	ó		30. Name and address of person who				411	I. WA	4 /111	TANU MER	MA	acquel
			31. Date filed (Month, Day, Year)	2 0 213 (Figistra)	r's Signature -	100		LNA	, VILVE	-1-1-1-1	1-10	
	Sta Registr		JAN	Z U ZOUTS	place of the stand	1	-					

1	For State Registrar		aryland / Dep <i>Ce</i>	rtificate of		F	Reg. No.	01090
Physician	Decedent's Name (First, Middle, L. T. 1. 1		Chiaia	11 <i>i</i>	Con	2. Date of Dea Month		3. Time of Death
/Medical -	Elder A	nthony	Ghigia	relli	Sr.	January		
	4a. Fecility Name (If not institution, g				, or Location of Dea	ath	4c. County of Dec	
	Anne Arundel Me			Annapo			Anne Ar	
rector	5. Social Security Number 198-14-1285 Usuel Residence of Decedent	Sex 7. Ag	e (In yrs. last birthday) 86 Yrs.	Months Day		March I	28, 1917 9. Bi	rthplace (State or Foreign PA
	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limit
to to	MD Anne A	rundel	Gle	n Burnie	2			1 ☐ Yes 2X N
r tems 23e or 28e-f e other mast be notified Funeral Director	10e. Street and Number			10f. Zip Code)		10g. Citizen of What C	country?
4 0	310 Baylor Road			2	21061		U.S.A	Α.
ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of	f Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rece - Am Black, Wh	
b b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		№1942 - 1946	1 Yes 2 N		nio rican, etc.)	Specify: Wh	
Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece (Give	dent's Usual Occ	supation ne during most of wired)	orking	16b. Kind of Busines:	s/Industry
Ma dr	Elementary/Secondary (0-12)	College (1-4or)+) l		red)		U.S. Goven	********
S		4	Draft	sman				nment
Be N	17. Father's Name (First, Middle, La	st)				ame (First, Middle,	Maiden Sumame)	
1 P	Unknown				Unkno			
traum	19a. Informant's Name/Relationship Mr. John Ghigiar					Rural Route Numbe n Burnie,	r, City or Town, State, MD 21061	
	20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name of	deed.	Date	20c. Location - City o	r Town, State
ny or	X□Burial 2 □Cremation 3 3 4 □Donation 5 □Other (Spe		Old Forg				Old Forge,	, PA
any inju	21. Signature of Funeral Service Lic		220 1	2. Name and Add Second	dress of Facility S	ingleton W Glen B	Funeral Ho	ome, P.A. 21061
ian ical	23a and Enter the disease, co shock, or heart failure list on Immediate Cause (Final disease or condition resulting in death)		the death. Do not enter the de				rest,	Approximate Interval Between Onset and Death
e burial-tra	Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	b. Due to (or as	stase a aurisaquenos of):	rench	dise	9582		7lyee/
be detached for use as it by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnar ⊒ Other (s <i>pecity)</i>			23d. Date of de Month	elivery Day Year
e detac	Part II. Other significant conditions	contributing to death b	out not resulting in the t	andertying cause o	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
						1 □ Y	es 2□No 3□	Probably 4 Unknow
N Q						24a. Was a autop perfor	sy prior to med2 death?	tutopsy findings available completion of cause of s
Be Co	25. Was case referred to medical examiner?					eath (Check only or	ne)	
al dire	1 Yes 2 No	Hospital: 1 Inpatio	ent 2 ER/Outpatie	nt 3□ DOA C	Other: 4 Nursing	Home 5 ☐ Resid	lence 6 Other (Sp.	ecify)
led in by the funeral Certification:	27. Manner of Death 1	28a. Date f Inju (Month, Da ion	ry 28b. Time o ly Year) Injury	W	lury at vork? □ Yes 2 □ No	28d. Describe h	ow injury occurred	
tifica	3 Suicide 6 Could no determine	286. Place of in	ury - At home, farm, st c. (Specify)	reet, factory, offic	Ce .	28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
<u>e</u> <u>e</u>	A	Physician: To the best aminer: On the basis of	f examination and/or in	th occurred at the nvestigation, in my	time, date and pla y opinion, death oc	ce, and due to the c curred at the time, c	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
Metely filled in	29a. Certifier (Check only one) Certifying 2 Medical Exponents	and manner st						
completely filled in by the funeral director, page Medical Certification: To Be Com	(Check only 2 Medical Ex	and manner st		29c. Lice	ense number	2	29d. Date signed (Mor	ith, Day, Year)
completely filled in	(Check only 2 Medical Ex	and manner st				cj i	29d. Date signed (Mon	ith, Day, Year)
To the Funeral Director: completely filled in by the Medical Certifical	(Check only 2 Medical Ex	tun	death (Item 23a) (Type		onse number DZ480	4	29d. Date signed (Mon	oth, Day, Year)

			1 - For State Registrar	State of	Maryla		artmen <i>rtificat</i>				lental Hy	giene Reg. No	200		010) 4 4
п	Physici	an	1. Decedent's Name (First, Middle,								2. Date of De	Da	y Ye	er	3. Time o	
	/Medio			Archie		Grant					Januar	y l	7 20	ő4	3:30	A. M
	Examir	er	4a. Fecility Name (If not institution,						Location of	of Death		4c.	County of [_	
			Genesis Elde 5. Social Security Number			Lane		ltimo	ore If Under	24 Hrs	9 Date of Birt	•			unde	
P	Funeral Director		241 36 5122	1.XM 2□F	. Age (111 yr	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da Sept. 1	Year	9.	Country	ce (State	orForeign olina
			Usuel Residence of Decedent								pepe. I	0,1	20 11	OL OI	Car	OTTIG
	nylanc how		10a. State 10b. County		i	City, Town or Lo								100	d. Inside C	ity Limits
	B Ma	ctor	Maryland Anne	Arundel		Baltimo	re								1 🗌 Yes	2 <u>⊠</u> No
	death with the Maryland ms 23a or 28a-f ehow finals be notified at	Sire.	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wha	Countr	y?	
	ath w	ie.	211 Audrey Av	enue				212					U.S.A	•		
	after dea or Itams	une	11. Marital Status	12. Was Deced	es?	U.S. 13.	Was Deced If Yes, spec	dent of Hi	spanic Ori n, Mexican	gin? (Sp ı, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V			
36	hours after tural', or ita	by Funeral Director	1 Never Married 2 Married 3 XWidowed 4 Divorced	ed 1 2 Yes 2 If Yes, Give Year or Dat	_	TT	1 🗆 Yes	2 💢 No	Specify:				Specify:	Whi	te	
5-0036	n 72 hours after death with the Marylan *natural', or Itams 23e or 28s-f ehow solical Examiner resal be notified at	ed	15. Decedent's	s Education		16a. Dece	dent's Usua	al Occupa	tion			16b. K	ind of Busine	ss/Indu	stry	
215	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	for 5+)	(Give	kind of wo DO NOT us	rk done d se retired,	uring most	t of work	ing				•	
2121	filed wit Hygien ther th	Completed	, , , , , , , , , , , , , , , , , , , ,	2 year		Sa1	es					I	nsurar	ce		
pu	2 should be filed within and Mental Hygiene. is marked other then eumatic event, tre Ma	Be	17. Father's Name (First, Middle, L.								e (First, Middle,					
yla	Men Men arke	ဥ		Archie Gr	ant						May Wa					
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other treumatic event, ILE MODE.		19a. Informant's Name/Relationshi Patricia Watki		htor		ng Address Yadki				al Route Numbe					00276
	1 and Healt em 2 ther		20a. Method of Disposition	ins / Daug		. Place of Dispo			all		Raeford Date		cation - City			20370
Baltimore,	nt of nt of :: If it		1 Burial 2 ☐ Cremation		ate	cemetery, crei	natory or o	ther place								
Iţi	artme artme ortani injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service □		Lo	akeview					/2004		esvil:			
Ba	permi Depa Impo eny ir		Commo.	Manne	4000	An In	001 B	id Address	io Ui	eor	ge J. Go ay Balt	once	Fune	cal 1	Home,	P.A.
8760,	/Medical Examiner physician and physician and physician and physician sit physician si	Icai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. EM Due to (or Due to (or	r as a conse	equence of): equence of):	A Lin	N.						C	iterval Bet onset and I	
P.O. Box 68	it the death certifica by the attending pt tached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	h 2 ☐ Fe nt at time of nn	etal death 3	Ectopic pro Other (sp	ecify)					23d. Date of Month	Da	ay h	fear
Records,	v requires that been signed should be de	by	Part II. Other significant condition	s contributing to dea	th but not re	esulting in the u	nderlying ca	ause give	n in Part I.				se contribut		cause of d	
_		Completed									24a. Was a autop: perfor 1 ☐ Yes	sy	death	to comp	iletion of c	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				. Othe	V		Check only or				-	_
of	Phys r this ral di	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		8c. Injury	4 Nur	_	me 5 \ Residence			pecify)		
on	ding Phy th. : After thi funeral o	ţ.	1 Avatural 5 Pending 2 Accident investiga	(Month,	Day Year)	Injury	м	Work'				or nijar	, 00001100			
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	f Injury - At , etc. <i>(Spe</i> c	home, farm, str	eet, factory	, office			28f. Location (S City or Town	treet and n. State,	d Number or	Rural R	loute Num	ber,
3	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Check only one)	Physician: To the bas and manne	is of examin	nowledge, death	occurred a	at the time	nion, deat	place, h occurr	and due to the cred at the time, d	ause(s) late and	and manner place, and o	as state	ed. e cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	-				. License					signed (Mo			
174	211		1.1000				(V3-	7111		U6, B	1/	19/0	14		
	()Y)		30. Name and address of person w	ho completed cause	of death (Ite	em 23a) (Туре,	Print)	A = =	10 C	/	1,7	Λ-/	47° M4		MD	
- 1	V		AKAIOUUI	17 / 66	6 (OHV	NV IV	101			06,5	771	ישייינ	_	2122	-5
	Sta Registr	_	31. Date filed (Month, Day, Year)	2 0 2004 b	istrar's Sign	inginite Co.	P	134.10								

Physician /Medical

Examiner

Funeral

Director

Completed by Funeral Director

Be

2

Completed by Physician/Medical Examiner

Be

Certification: To

Medical

Physician /Medical Examiner

E	State of M	aryland	I / Depa	artmer	nt of H	ealth a	nd M	fental Hyd	giene	00-	
For State Registrar					te of L				leg. No.	200	+ 01045
Decedent's Name (First, Middle, La		7.500						2. Date of Dea	th Day	Year	3. Time of Death
	NDON	JACO	В		GRAI		4 D 45	Jarwas	-	1	7 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
a. Fecility Name (If not institution, give					Town, or	Location o	f Death		4c.	County of De	N/A
Sinai Hospital o		je (In yrs. la	st birthday)	If Unde	r 1 Year	If Under 2		8. Date of Birt	h	9. B	irthplace (Stete or Foreign
	1 X M 2□ F	-	Yrs.	Months	Days	12	Min.	JAN. 11	$\frac{7}{200}$	4	Country) MD
Isuel Residence of Decedent Oa. State 10b. County		10c City	Town or Lo	cation							10d. Inside City Limits
	TIMODE	Too. Oity,		NGS M	ATLLC						1 ☐ Yes 2 ☐ No
MD BAL	TIMORE		OWII		i I L L S			T	10g. Citiz	zen of What (Country?
21 PREAKNESS CO	IRT					211	17				U.S.A.
1. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	i. 13.	Was Dece	edent of H	spanic Orio	in? (Sp	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh	nencan Indian,
1 X Never Married 2 ☐ Married	1 Yes 2 X			ii res, spa 1 ∐ Yes		Specify:	, ruento	ricari, etc.)		Specify:	WHITE
3 Widowed 4 Divorced	Year or Dates:							1			
15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give life.	kind of w	uai Occupa ork done d use retired	furing most	of work	ing	16b. Kii	nd of Busines	s/industry
Elementary/Secondary (0-12)	College (1-4or	5+)	NONE			,					NONE
17. Father's Name (First, Middle, Las	1)					18. Mothe	r's Nam	e (First, Middle,	Maiden	Sumame)	
BRIAN	М.		GRANI	ΞK			JEN	INIFER			STYAR
19a. Informant's Name/Relationship								al Route Numbe			
BRIAN GRANEK /	FATHER	1001 01				COUR		OWINGS			
t0a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 [Removal from State	CO	ace of Dispo metery, crei	matory or	other plac			Date			or Town, State
`4 □Donation 5 □ Other (Speci		BET	H TFII	_				/2004	_	DLAWN,	
21. Signature of Funeral Service Lice	gsee CHIV	7				s of Facility					S., INC. E. MD 21208
23a. Part1. Enter the disease, or con	nplications that cause	d the death.								SVILLL	Approximate
shock, or heart failure. List only Immediate Cause (Finat			,	,							Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as	a consequ	ence of)	pop!	as11	-					12 hours
	a. Pulmo. Due to (or as	m E	Pren	12+4	ri+	4					
Gequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as	a conseq	ence of):			0					
Cause (Disease or injury that initiated events	с.										
resulting in death) Last	Due to (or as	a consequ	ence of):								
	d										
IF FEMALE:	23c. If yes, outcome	of pregnan	icv							23d. Date of d	leliven
23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[∃Ectopic (pregnancy specify)				1	Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
Part II. Other significant conditions	contributing to death !	but not resu	lting in the u	ınderlying	cause giv	en in Part I.		23e. Did to	obacco u	se contribute	to the cause of death?
								10	es 2	Mo 3□	Probably 4 Dunknown
								24a. Was		24b. Were	autopsy findings available completion of cause of
									rmed? 2 No	death'	?
25. Was case referred to medical examiner?					-		of Deat	h (Check only o	ne)		
1 ☐ Yes 2 No	Hospital: 1 Inpati		R/Outpatie			4 LI Nu	rsing Ho	ome 5 Resid			pecify)
27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Yeer)	28b. Time o Injury	M	28c. Injun Work	/at <br Yes 2 ⊟I	No	28d. Describe I	iow injur	y occurred	
2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	be 390 Blace of In	niury - At hor	me farm st			163 2	40	28f. Location (Street an	d Number or	Rural Route Number,
4 Homicide determined	building, e	itc. (Specify,)	.501, 10010	· / · VIII VO			City or Tox			
29a. Certifier Certifying P	hysician: To the bes	t of my knov	vledge, deat	th occurre	d at the tir	ne, date an	d place,	and due to the	cause(s)	and manner	as stated.
(Check only 2 Medical Exa	miner: On the basis of and manner s	of examinati	ion and/or in	vestigatio	n, in my o	pinion, dea	th occur	red at the time.	date and	place, and d	ue to the cause(s)
29b. Signature and title of certifier	Austin	all		V) 2	9c. Licens						nth, Day, Year)
> Hama	10000C		mI	U	0003	3763	0	1	Tano	vary	11, 2004 timore
	completed cause of	death (Item	232) (Tues	Print)						Bal.	L 200=6

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

> State Registrar

31. Date filed (Month, Day, Year) JAN 2 0 2004 32. Registrar's Signature

Homa Niknats, mD Sinai Hospital

2401 W. BEIVEDETE AVE.

Md 2/2/5

ORIGINAL

			For State				artment of H		ınd Mer	ntal Hygi	00	ΩI.	01016
		_	1. Decedent's Name (First, Middle, L		./ 1/30	104 she 1	unicate of L	Jeain	12	Reg		UH	3. Time of Death
	Physicia		CHARLES	HILTNI	ED					Month	Day	Year	LOSV AM
N	/Medic Examin		4a. Fecility Name (If not institution, g				4b. City, Town, or	Location of	f Death	01	4c. County	of Death	0.78
	CXUITIII	C1	University of New	yland Medi	111 (21	ikv	Baltin	nove_			N	A	
	Funeral			Sex 7. A		last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Min.	Date of Birth (Month, Day,	(ear)	9. Birthpl	ace (State or Foreign
	Director		218-64-7799	XIM 2□F	48	Yrs.	Working Days	110010	N	ov.5,1	955		yland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10	Od. Inside City Limits
	Mary f sho	ţo	MD Balt	imore				Bal	timo:	re			1 ☐ Yes XXXNo
	r 28e	Funeral Director	10e. Street and Number				10f. Zip Code	,			g. Citizen of W	/hat Coun	try?
	th with	alD	8035 Lansdale	Road			2122	24			USA		
	eme eme	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Orig	gin? (Specify	Yes or No-		- America k, White, e	
36	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23s or 28e-f show the Modical Excit file must be notified at	by Fu	1 Never Married 2 Married	If Yes, Give		1	¹□Yes 2□XNo	Specify:		,		Whit	
8	hour turel	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	-	163 Dece	lent's Usual Occupa	tion		144	Sb. Kind of Bu		
<u>.</u>	n "na	plet	(Specify only highest g	rade completed)		(Give	kind of work done di DO NOT use retired)	urina most	of working	"	ob. Kind of Bu	SITIESSVITIO	ustry
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Truc	k Driver	-			J.B.H	unt	
2	al Hy d othe vant,	Bec	17. Father's Name (First, Middle, Las	st)				18. Mother	r's Name (Fi	rst, Middle, Ma	aiden Sumam	Θ)	
Maryland 21215-0036	2 should be liled within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or iteme 23a or 28e-f show 'eumatic evant, the Mudical Exprimer must be notified at	²	Charles Hil					An	ına E	. Cran	ie		
ā	s 1 and 2 should if Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship	, , , ,			g Address (Street a						
	s 1 and 3 if Health item 27 other tre		Harriet Hiltn 20a. Method of Disposition	er/wire	20b. P	lace of Dispo	5 Lansda sition (Name of		Date	1 20	ore M		
no	Pages nent of I int: If it		12☐ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		Ho.	emetery, cren LlyHi	l I Cemete	ry 1	/20/0)4 E	altim		
Baltimore,			21. Signature of Funeral Service Lice		10/		. Name and Address	i					
ñ	permit. Departimport Import any inj		* K Time	1 600	. IV	u	300 Mac	70 A	Conn	ellyFu	ineral	Home	eofEssex
b			23a. Part1. Enter the disease, or co shock, or heart failure. List en	pefications that cause y one cause on each t	d the death	00 not ent	er the mode of dying	, such as o	cardiac or re	spiratory arres	t,	212	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Small	1 (011	Line	Cancer						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	uence of):							_
		-	Sequentially list conditions, if any, leading to immediate	bbue to (or as	pina	1 Tuch	astusis						3 weeks
	rted nsit	ulne	Cause (Disease or injury	200 10 (01 23	a consequ	derice or).							
<u>,</u>	execun n and ial-tra	Examine	that initiated events resulting in death) Last	C Due to (or as	a consequ	uence of):							
8760	death certificate be executed e attending physician and id for use as the burial-transit	dlcal	•	d									
Ö	ing ph	Med	IF FEMALE:										
Box	eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3	Ectopic pregnancy				23d. Date Mon	of deliver	y Day Year
_	at the de by the a tached f	ysic	1 Yes 2 No	4□Pregnant a 9□Unknown	it time of de	eath 5	Other (specify)				191011		Say Toda
J.	The law requires that the te has been signed by thoage 2 should be detached.	/ Ph	Part II. Other significant conditions	contributing to death t	but not resu	atting in the ur	iderlying cause give	n in Part I.		23e. Did toba	cco use contri	bute to the	cause of death?
Vital Records,	quires n sign	d by								1 ♥ Yes	2 🗆 No	3 🗌 Proba	bly 4 □Unknown
S	s been si	olete								24a. Was an	24b. W	/ere autop	sy findings available
ř	The lav	Completed								autopsy performe	id? d	eath?	pletion of cause of 2 🖾 No
<u>E</u>		BeC	25. Was case referred to medical examiner?					26. Place		1 Yes 2	2140	165	I A NO
010	hysic this ce at dire	Tol	1 Yes 2 KNo	Hospital:		ER/Outpatien		4 📋 (40):	sing Home	5 Resident	ce 6 Othe	r (Specity)	
Ĕ	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	28c. Injury Work		1	Describe how	injury occurre	ed	
Division	Attendii death. ctor: A y the fu	cat	2 Accident investigate 3 Suicide 6 Could not	be as Place of In	iun, At ho	me form stre	M 1 ☐ Y	es 2□N		Location (Stro	at and Alumba	r or Pural	Route Number,
<u>≥</u>	after after Direct	Certification:	4 Homicide determine		tc. (Specify		oot, factory, office		201.1	City or Town,	State)	or Hurar	noute Number,
	pspite hours meral y filler		29a. Certifier 1 Certifying F	hysician: To the best	of my know	wledge, death	occurred at the time	e, date and	place, and	due to the cau	se(s) and mar	ner as sta	ted.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Attenthis certific completely filled in by the funeral director.	edical	Une)	aminer: On the basis of and manner st	tated.	ion and/or inv	estigation, in my opi	inion, death	h occurred a	t the time, date	and place, a	nd due to	the cause(s)
	vith To T	Σ	29b. Signature and title of certifier	÷ A	118		29c. License			29d	. Date signed	(Month, D	ay, Year)
•	1.		Zuli de	weekst	MID		PILES				1117/	04	
	1. (1)		30. Name and address of person who	o completed cause of a	death (Item	23a) (Type, I	Orint\		-				
	Q		1 . 1 1	8	77	50.	th GRED	NO	TREO	V Bi	LTO. 1	45.	
	Sta	te	Linda Lew (1) 31. Date filed (Month, Day, Year)	ndowski 32. Regist	2 Z	Sout	th Gree	Ne S	Tree	Y Da	LTO. 1	45.	

Ter 04-	ry Lee ·0474	Н€	elmsetter, Jr Please 1	Type or F	Print in	Black in	delible	ink.	Ensu	ıre Al	l Copies	Are L	egible		
AKC	3		1 - For Unpend Item #23a Registrar/mend Item 1 po	State of &27 per n er ME,G82	Marylar 8,02/13	395/J&Pt 704dh& <i>e</i>	artmen as rtificat	e of L	ealth a Death	and M	2. Date of De	giene Reg. No. (200	4 0	0 L 7
	Physicia	an	Decedent's Name (First, Middle, Last Terry Lee	/ Terry Helmstc			tetter	Jr.			Month	Day	Yea	ar	М
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death	Janu		7 , 20 ounty of D	01	05 A
	LXdiiiii		6335 Orchard Clu	b Drive	Apt.	1	El	krid	.ge			Но	ward		
<i>U</i> ,	Funeral Director		213-90-3488	x 2√2M 2□F		last birthday)	tf Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Mar. 2			Birthplace (SI Country) arylar	ate or Foreign
	aryland show,	_	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo							<u> </u>		de City Limits Yes 2X No
	the M	Director	Maryland Howard 10e. Street and Number			FIVIT	10f. Zip	Code	-			10a Citiza	n of What		
	with I		6335 Orchard Club	Drive	#001			2107	5			· .	ed St		
	death	Funerai	11. Maritat Status	12. Was Dece			Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No)- 14		merican tndia	ın,
920	4 within 72 hours after death with the Maryland jiene. I then "natural", or Iteme 23a or 28e-f ehow. It a Medical Examinat must be nutified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Tes If Yes, Give Year or Da	2%∏{ No		If Yes, spec		n, Mexicar Specify:	n, Puerto	Rican, etc.)	S	Black, W	hite, etc. White	
21215-0036	within 72 ho ene. then "natur ne Medical	Completed	15. Decedent's Edit (Specify only highest grade Elementary/Secondary (0-12)		-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired	turing mos)	t of worki	ng			ss/Industry	
		Con	12			Col	lecti	on A		4. 11.	2000 A 841.4184			Maryla	ınd
and	d tal	Be	17. Father's Name (First, Middle, Last) Terry Lee Scott He	lmstatt	or Si	^					(First, Middle Ann Whe	_	umame)		
Maryland	should I	은	19a. Informant's Name/Relationship (T		CI, DI		na Address	(Street a			I Route Numb		Town, State	e, Zip Code)	
	3 8 8 5		Sheila Elliott - M	lother			-				e #001			MD 21	.075
ore,	of Health of Health litem 27		20a. Method of Disposition		1	Place of Dispo	sition (Nar	ne of			Date	20c. Loca	tion - City	or Town, Sta	te
Ë	Pagement annt: H		1 XBurial 2 □ Cremation 3 □ I 1 4 □ Donation 5 □ Other (Specify,		Mea	adowrid	lge Me	m. P	ark	1/21	1/04	Elkr	idge,	Maryl	.and
Baltimore,	permit. Pages to Department of Himportant: If ite any injury or ot one		21. Signature of ameral Service Cicens)	Moi	290 \$	2. Name an	nd Addres	s of Facility ufmar	i Fur	eral H	ome A	t MMF	., Inc	. 01075
	40260		23a Part I Enter to disease or como	lications that ca	,								e, Ma	Ly Laire Approx	
			23a. Part1. Enter y e disease, or comp shock, or he in failure. List only o tmmediate Cause (Final							oai oigo c	n respiratory a	11031,		Interva	Between and Death
4	Physician /Medical		disease or condition resulting in death)	a.	SCLETOTI or as a conse	c Cardio	vascul	ar Di	sease					-	
	Examiner		0 0 1 5 5 5 5 5 5	b										1	
	D #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		or as a conse	quence of):									
	xecuted and il-transit	xami	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to /	or as a conse	quence of):									
60,	be ed ician buria	ш			. 45 4 55/165	420.100 01/.									
68760	tificate ng phys as the	ledicai		d											
Вох	death certificate e attending phys ed for use as the	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregr		∃Ectopic pr					23	d. Date of	delivery	
	e death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		Other (sp						Month	Day	Year
P.0	that the de ed by the detached		9 Unknown Part II. Other significant conditions co	intributing to de	ath but not re	sulting in the	inderlying c	ause dive	en in Part I		23e. Did 1	tobacco use	contribute	e to the cause	e of death?
Records,	uires l signe	d by				.					10				4 🔲 Unknown
00	The law requires ite has been signinge age 2 should be	ompieted									24a. Was		24b. Were	autopsy find	ings available
	The la ate has page 2	ome									acto perfo	psy ormed? 2 \(\subseteq \text{No} \)	death	to completion es 2□ No	
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?							of Death	Check only				
of V	Physician: this certific al director,	은	1XX es 2 □ No			ER/Outpatie			4 🗀 140		me 5 Resi			pecify) At	scene
no		tlon:	27. Manner of Death 1	28a. Date o (Monti	h, Day Year)	28b. Time o	M	28c. Injury Worl 1 □ 1	/at ⟨? Yes 2□		28d. Describe	now injury	occurreo		
Division	en eat or:	fical	3 Suicide 6 Could not be	28e. Place	of Injury - At I	home, farm, st					28f. Location (Number or	Rural Route	Number,
Ö	= = = =	Certification:	4 Homicide	buildir	ng, etc. (Spec	uty)					City or To	w⊓, State)			
	To the Hospitel or within 24 hours afte To the Funeral Dirt completely fitled in the Funeral Dirt completely	Medical	29a. Certifier 1 Certifying Phyone) 1 Madicat Exam		isis of examin										use(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	(A.			296	c. License	number			29d. Date	signed (Ma	onth, Day, Ye	ear)
			Mayne 1	nelsh	ell	WV	0.	C.M.	E.			Janua	ry 18	2004	
			30. Name and address of person who d	ompleted cause	e of death (Ite	эт 23а) (Турө		_	- 0:					15	
	Sta	ato:	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	nature			n Str	eet,	Baltir	nore,	Mary	Land 2	1201
	Registi		JAN 2 0 2004	Bener	egistrar's Sign	9 4	rocks	f.							

		1 - State Registrar				nt of Health and te of Death		Reg. No. 2	004	0 1 12 1
hysici	an	Decedent's Name (First, Middle, Last Martha Gordo		n			2. Date of De Month	Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give			4b. City	, Town, or Location of De	ath Oct D	7-5	unity of Deat	7
- A a i i i i i	iei	Union Memorial Ho				Baltimo			N/A	
neral		5. Social Security Number 6. Se 217–01–7958	7. Age (In yrs. last birthday,	If Unde Months	er 1 Year If Under 24 H Days Hours M	n. (Month, Da			hplace (State or Fore untry)
ector		Usual Residence of Decedent		94 Yrs.			Jan 1,	1910	Mary	yland
How H		10a. State 10b. County	- 1	Oc. City, Town or Lo						10d. Inside City Lim
8a-fa	cto	Maryland N/A		Balti						XXYes 2 □ I
ed other than "natural", or tema 23a or 28a-f show event, the Medical Examinat must be notified at	Funeral Director	10e. Street and Number 3353 Falls Road			10f. Zi	p Code 21211		10g. Citizer	of What Co	untry?
TIME AND THE REAL PROPERTY.	eral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Dece		(Specify Yes or No	o- 14.	USA Race - Ame	rican Indian,
THE REAL PROPERTY.	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give		If Yes, spe	edent of Hispanic Origin? ecify Cuban, Mexican, Put	erto Rican, etc.)		Black, White	
LEN.	d by	3℃Widowed 4 Divorced	Year or Dates:		1 1 105	XXNo Specify:		Sp	ecify: V	white
Miles	Completed	15. Decedent's Edu (Specify only highest grad	fe completed)	(Give	dent's Usu kind of w	ual Occupation ork done during most of w use retired)	vorking	16b. Kind	of Business/	ndustry
The M	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Weigh				Md Bo	lt & N	Tut Co.
vent,	BeC	17. Father's Name (First, Middle, Last)	_				ame (First, Middle,			
is marked aumatic ev	To	William Thomas Go	ordon			Alice	Crue			
		19a. Informant's Name/Relationship (T)		1	-	s (Street and Number or i				
ther t		Patricia Chalk 20a. Method of Disposition	Daughter	20b. Place of Dispo	6.00		Baltimore Date		yland ion - City or 1	
00/		XX Burial 2 ☐ Cremation 3 ☐ F		st. Mary	matory or	other place)	7/2004			ryland
any injury or other once.		*4 □ Donation 5 □ Other (Specify) 21. Signat		2:	Name a	nd Address of Facility				
any ii		March 1	ara-th	B	urgee	-Henss-Seit alls Road B	z Funeral	Home Mark	Inc.	1011
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications hat caused the	e death. Do not en	ter the mo	de of dying, such as cardi	ac or respiratory a	rrest,	ranu z	Approximate Interval Between
ician		Immediate Cause (Final disease or condition	stroke							Onset and Death
dical liner		resulting in death)	~	consequence of):						Six day
nier	_	Sequentially list conditions.	o Atrial	Fibrillat	noj					Five do
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence on:						
ial-tra	Exai	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):						
he burial-transit	cal		d							
attending pny	by Physician/Medi	IF FEMALE:								
or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2	Fetal death 3	Ectopic p			23d.	Date of delive	very Day Year
ched	yslc	1 ☐ Yes 2 💆 No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5L	Other (s)	oecify)				July 104.
been signed by me should be detached	y Ph	Part II. Other significant conditions co	ntributing to death but i	not resulting in the u	nderlying (cause given in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
uld be							101	Yes 2⊠N	o 3□Pro	bably 4 Unknow
2 sho	plet						24a. Was		4b. Were aut	opsy findings availal
page	Completed							rmed? 2 ⊠ No	death?	ompletion of cause of 2 2 No
ector.	Be (25. Was case referred to medical examiner?				26. Place of De	eath (Check only o			
dire	2	1 ☐ Yes 2 ☒ No	Hospital: 1 🔀 Inpatient	2 ER/Outpatier			Home 5 Resid			(fy)
funera	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury		28c. Injury at Work?	28d. Describe h	now injury oc	curred	
y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	· At home, farm, str	M factor	1 Yes 2 No	28f Location (5	Street and Ni	umber or Rui	al Route Number.
d in d	erti	4 Homicide	building, etc. (Specify)		y, ses	City or Tou			a. 7.100,10 770,11001,
elly fille	Medical C	(Check only 2 Medical Exami	ner: On the basis of ex	amination and/or in	n occurred vestigation	at the time, date and place, in my opinion, death occ	ce, and due to the courred at the time,	cause(s) and	i manner as s	stated. to the cause(s)
	Med	29b. Signature and title of certifier	and manner state	1.		c. License number		29d. Date sig		
mplet			AN							
completely filled in by the funeral director, page 2		MANUANA . N			1 1	1 91.3 891.		100000	CLE IT	1 0001
complete		30. Name and address of person who co		h (Item 23a) (Type		17 243 89 4		Jonna	oxy,15	5,2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 7:00 AM **Physician** HOB 12,2004 10 January /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner 13 a / f. more Min B. Wonths Days Hours Min B. 16 nd Mary 16
5. Social Security Number Neral 9. Birthplace (State or Foreign Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2□F Months 213-80-515 1-5-73 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ne 23a or 28e-f shov must be notified at 1 Yes 2 No Balt: more Funeral Director 10g. Citizen of What Country? 10e Street and Number U. S.A. 14. Race - American Indian, item 27 is marked other than "natural", or Items other traumatic avent, the Medical Exercitival in 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be tited within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "natural", or iten any injury or other traumatic avent, the Medical Estarium. ODE. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) esturant 12+h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andre Cora Robertson Du 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto. Md. St. 20b. Place of Disposition (Name of cemetery, crematory or other place) Hobb Jane 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bay Dundalkm * 4 □ Donation 5 □ Other (Specify) View Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5r funeral Hone Wesley Chinis Sr fu 2007 Eastern Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL **Physician** /Medical HEART DISEASE **Examiner** YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner MELLITUS DIABET ES YEARS The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 2 No 9□ Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KLIDNEY CHRONIC 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown PERIPHERAL VASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No After this 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1. Natural 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie JAN. 14,2004 luca BALT. MD 2/2/8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 hd 81 # 523 JOSE S. ALMARIO 200

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Yeer)

ORIGINAL

32. Registrar's Signature

Eng.

JAI JAMEST

			1 - For State Registrar	State of Maryland / Depa		lental Hygie	_
	Physici	an	1. Decedent's Name (First, Middle, Last) Boyd Peter	Himmelhoch		2. Date of Death Month Januar	Day Yeer 3. Time of Death
>	/Medic Examir		4a. Facility Name (If not institution, give s Calvert Memorial	treet and number)	4b. City, Town, or Location of Death Prince Frederick	Junuar	4c. County of Death Calvert
	Funeral Director		5. Social Security Number 6. Sex 121–10–8209		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y JAN 31,	
Ī	Maryland -f show find at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford	10c. City, Town or Lo Abingdon	cation		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28a ast be not	Funeral Director	10e. Street and Number 618 Nanticoke Cour	·t	10f. Zip Code 21009		g. Citizen of Whaf Country? SA
920	be filed within 72 hours after death with the Maryland ntal Hygiene. It do than "natural", or flams 23a or 28a-f show other than "natural" to Medical Extraction trust be deathed at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 NYes 2 No 1 Q/₁ 3 -	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho ane. Ihan "natur a Mazical I	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	Sb. Kind of Business/Industry
land 2	be filed stal Hygi st other event, I	To Be Co	17. Father's Name (First, Middle, Last) Edward M. Himmelho		18. Mother's Nam Annette	e (First, Middle, Ma	
	and ealth n 27 nar tr		19a. Informant's Name/Relationship (Type Pauline Reichenbace	ch/Friend 618	ng Address (Street and Number or Rur Nanticoke Court	Abindon	DOSCO: HANGINGSHIP
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify) 21. Signature (Fu eral Service License)	Metro Cr	matory or other place) ematory Inc. 1-18	3-04 B	altimore, MD
Ba	permit. Departr Imports any inje		Thomas Grego		Name and Address of Facility Cremation Society 299 Frederick Roac Let the mode of dying, such as cardiac	l Balti	more, MD 21228
	r nysician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Preumon Due to (or as a consequence of):	9		Interval Between Onset and Death 3 Cays
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 6	that the death certificated by the attending (Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta			tributing to death but not resulfing in the u			cco use contribute to the cause of death? 2 No 3 Probably 4 Tunknown
of Vital Records,	The law reate has been	Completed by	Peripheral Vasu Atheroscienotic	ilaz Disease, Cardiovuscula		24a. Was an autopsy performe	
f Vita	ysician: is certific director.	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No H	ospital: 1 ☑Inpatient 2 ☐ ER/Outpatier	26. Place of Deat	h <i>(Check only one)</i> me 5 🗆 Residen	ce 6
Division o	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Yeer) 28b. Time o Injury	Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	
Divis	To the Hospital or Attanding I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer		4 Homicide determined	28e. Place of Injury - At home, farm, stebuilding, etc. (Specify)		City or Town,	
171	the Hosp in 24 hou the Fune spletely fi	Medicai	(Check only 2 Medical Exemir one)	sicien: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	e and place, and due to the cause(s)
	To Too	2	29b. Signature and title of certifier	E hinana.	29c. License number D 5065	3	1. Date signed (Month, Day, Year) 1 - 1 7 - 2004
	Mr,		5851 - Deale		Print) GYAN - C oad Deale		
	St Regist	ate rar	31. Date filed (Month, Day Year) 2004	34 Registrar's Signature	SALA.		

					State of	Maryla		irtment of <i>tificate o</i>		d Mental H	ygiene Reg. No. 2 (004	01052
			1. Decedent's Name	(First, Middle, Last)					2. Dete of D	eath		Time of Death
V.	Physici		Grace W.	Hastings						Janua:	Day CY 15,	Year 2004	12:00 PM
	/Medic Examir		4a Fecility Name (If		street and numb	oer)			4b. City, Town,	or Location of Dea			12.00 111
			Frederick	Villa					Cato	nsville	Balt	timore	
	Funeral		5. Social Security Nu			Age (In yrs	. last birthday)	If Under 1 Yea	ar If Under 24 h	Irs. 8. Date of B	irth	9. Birthplace	(Stete or Foreign
н	Director		212-05-10	40	□M 21⁄ДF	98	Yrs.	Months Day	s Hours M	May 9		Marylar	nd
	D		Usual Residence of							1/ 2		rat j tal	
	arylen show		10a. State	10b. County		10c. C	ity, Town or Lo	ation					nside City Limits
	the Maryle 28s-f sho	ō	Maryland	Baltimor	e	E	Baltimon	ce				1	☐Yes 2√2No
	or 28	E E	10e. Street and Num	ber				10f. Zip Code			10g. Citizen of	What Country?	
	23a d	a	11 Bonnie	Jean Cou	rt			21	207		United S	States	
	Herne Herne	Funeral Director	11. Marital Status		12. Was Decede	ent Ever in U	J,S. 13. V	Vas Decedent o	Hispenic Origin?	(Specify Yes or N	o- 14. Rac	e - American In	idian,
0	or the		1 Never Marrie	d 2 Married	1 ☐ Yes 2	 No		_	ıban, Mexican, Pu	eno Alcan, etc.)		ck, White, etc.	
02	ours	b	3 Widowed 4	Divorced	If Yes, Give Year or Date		1	□Yes 2√2N	o Specify:		Specif	Whit	e
5-0	72 hours efter death with the Marylend naturel; or Nems 23a or 28a-f show Sical Examiner must be nottried at	Completed by	(Snecil	15. Decedent's Edu	cation		16a. Deced	ent's Usual Occ	upation e during most of a	vodkina	16b. Kind of B	usiness/Industry	/
2	e e e	힐	Elementary/Secon		College (1-4	or 5+)	life. C	O NOT use reti	red)	vo.n.ing			
7	W Per	6	12		0		super	rvisor			phone	company	7
Maryland 21215-0020	A SE	Be	17. Father's Neme (F	First, Middle, Last)					18. Mother's N	lame (First, Middle			
<u>Ja</u>	ould be f Mentel I mrked of matic eve	10	George W.	Lemmon					Georget	ta Leish	ear		
an	of branch		19a. Informant's Nar	ne/Relationship (T)	/pe, Print)		19b. Mailin	g Address (Stre		Rurel Route Num		State, Zip Code	е)
	alth e 27 is		John Holl	man — fri	end		11 Bc	nnie Je	an Court	, Baltim	ore. Mar	vland 2	21 207
ē,	othe other	ļ	20a. Method of Dispo			20b.	Place of Dispos	ition (Name of etory or other p		Date	20c. Location	City or Town, S	State
٤	Pege nt: #			Cremation 3 □F □Other (Specify)		are	-	k Cemet	•	1/19/20	04 Balt	imore	Maryland
Baltimore,		ŀ	21. Signature of Fun		_	A >			-	lubbard F			
Ba	permit. Depertrimports any injure.		1110	in II	21 11	()						•	
_			M	114	XII	1				nue, Balt		laryland	21229
4			23a. Part1. Enter the shock, or heart	e disease, ør dompl failure. List only o	ications that ceu ne cause on eec	sed the dea h line.	th. Do not ente	r the mode of d	ying, such as card	liac or respiratory	arrest,	Inter	roximate val Between
	Physician			\circ		. /						Ons	et and Death
1	/Medical Examiner		Immediate Cause (F disease or condition			1/45	4/15	Deners	2'6			:	
	LAdillilei		resulting in death)			Due to (or as a consequ						
	₽ #	<u>ne</u>										i	
	ficete be executed physician enous the buriel-transit	Examiner	Sequentially list con-	ditions,	J	Due to (d	or es a consequ	ience of):					
68760,	e exercian e	<u> </u>	Sequentially list conditions, leading to improve ceuse. Enter Underline Cause (Disease or in	nediate ying									
376	ete b nysic the b	edicai	that initiated events resulting in death) La		3	Due to (d	or as a consequ	ence of):				1	
	ng pl												
Box	endi r use	Z			d							1	
	lew requires that the death certif as been signed by the ettending s 2 should be deteched for use e	Physician/M	Part II. Other signific	ant conditions cor	tributing to deatl	h but not res	ulting in the un-	derlying cause g	given in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
P.0	by the	اڅ									Yes 2□ No		4 Unknown
	es the igned I be del	ğ								-			
Ë	v require been sig should b	귷									an autopsy	24b. Were au	utopsy findings
ပ္ပ	w re	i ë								- peri	ormed?	complet of death	e prior to ion of cause ?
æ	0 - 0	Completed								40	Yes 2 No		
ā	ilcian: The		25. Was case referre	d to modical								1 L Yes	2□ No
⋚	ysician: is certifice director, p	o Be	examiner?	/	lospital:			-5		eath (Check only			
of Vital Records,	± ± ₽	⊢⊦	1 ☐ Yes 2 ☐ N 27. Manner of Death	0	28a. Date of I		ER/Outpatient 28b. Time of	3LI DOA	4 Le Nursing	Home 5 ☐ Res	how injury occurs		
	IIng After fune	5	1 Anatural	5 Pending	(Month,	Dey Year)	Injury	28c. Inj W	ork? ⊒Yes 2⊒No	28d. Describe	now injury occur	90	
Division	Attending or death. ector: After by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be	One Place of	Jairra, At h				206 Leasting	Change and Alicania		A- 61
₹	or Al effer Direction by	ŧ	4 ☐ Homicide	determined		etc. (Specil		et, factory, office	•		Street and Numb wn, State)	er or Hurai Hou	te Number,
	urs e urs e			-/									
	Hoeg Tune Telly f	Ca	(Check only 2	Certifying Phys	ner: On the basis	s of examina	wledge, death tion and/or inve	occurred at the testigation, in my	time, date and ple opinion, death oc	ce, and due to the curred at the time,	date and place, a	nner es stated. and due to the c	ause(s)
	To the Mospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medicai	one)		and manner	stated.							
	S t is c	-	29b. Signature and til						nse number		29d. Date signed	Month, Dey,	Year)
			1 Comm	men Mu	No			D 9	7683		1/15/0	4	
	10		30. Name and address	s of person who co	mpleted cause o	of death (Item	n 23a) (Type, P	rint)					
	V		Raymond Mi	li 25	Main Sa	vut =	smfe 2	200 Re	nkslowa	MD			
	Stat	е	31 Date filed (Month	Day, Year)	7 32. Regi	strar's Signa	ature 1	Proces	inks bus				
	Registra	ir .		JAN Z	O KUU	Marie Contract	flat Side	Edd of State	July 200				

		1	State of Maryland / Department / D	ntment of Health and M Tificate of Death	ental Hygien	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia	-	ROBERT HERNDON		JAN VARY	7 2004 0415 M
	/Medic	_	4a. Fecility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin	er	NORTHWEST HOSPITAL	RANDALLSTOWN	J, MD /	BALTIMORE
	∘ Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Director		212-46-8226 1XM 2□F 58 Yrs.	Widikiis Buyo Madie	AUG. 29,	
	p.	-	Usual Residence of Decedent 10a State 10b County 10c City, Town or Lo	cation		10d. Inside City Limits
	how		10a. State 10b. County 10c. City, Town or Lo	Callon		1X Yes 2 □ No
	Ba-f o	Director		TIMORE	10- 0	itizen of What Country?
	or 2	Sire	10e. Street and Number	10f. Zip Code	10g. C	itizen of what Country?
	23s		11 A SPINNERS COURT	21133		USA
	ams er	Ine	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	 Race - American Indian, Black, White, etc.
98	72 hours after death with the Maryland natural; or Itama 23a or 28a-f show alcal Examinatoryst by ricitified at	by Funeral		1 ☐ Yes 2 █ No Specify:		Specify: AFRICAN
5-0036	ural',		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	dent's Usual Occupation	160	AMERICAN Kind of Business/Industry
7	"nat	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)		Killy of Businessamadetty
2121	within ne.	m	College (1-4or 5+) PROGI	NE ST	п	ALTIMORE CITY
	iled v tygie her t	ပိ	1.Z Z FROGI	18. Mother's Name	(First, Middle, Maide	n Sumame)
Maryland	s 1 and 2 should be filed within 72 hours after dea f Health and Mental Hygiene. Item 27 is marked other then "natural", or Itams other traumatic event, Ita Medical Examiner m	Be c	ROBERT HERNDON SR	LILLIA	N MORRIS HERN LIAN HARR	NDON
Ž	hould d Me mark matic	2		ng Address (Street and Number or Rura	I Route Number, City	or Town, State, Zip Code)
Z	d 2 s th an 7 ts u		SHE	TLAND	TERTOWN. M	
	is 1 and 2 of Health item 27 (20a Method of Disposition 20b. Place of Dispo	osition (Name of		Location - City or Town, Stete
3altimore,	ages nt of :: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)	/O/ OUT	NCC MILLS MD
Ħ	t. Partmer rtant rtant njury	10		FOREST CEM. 1/23 2. Name and Address of Facility LTV		NGS MILLS, MD
Ba	permit. Pages 1 Department of H Important: If ites eny injury or ott			WI	LIE FUNERA	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	38 N. GILMOR STREE ter the mode of dving, such as cardiac		Approximate
			shock or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	MYDCARDIAL	(N)-AKC)	1070
	/Medical Examiner			,		
	4.5	_	Sequentially list conditions,			
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PANCREATI	T15.	
	and and I-tran	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	MICKURIT	/ / 0	
8760,	ate be executed hysician and ihe burial-transit					
87	physicate s the	dicai	d			
9 X	eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten for us	ian	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
	t the de by the a tached	ysic	1 Yes 2 No 9 Unknown			
P.0	hat the ad by detac	P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Vital Records,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transli	1 by			1 ☐ Yes	2 □No 3 □ Probably 4 → nknown
oro	w requir been si should	Completed			24a. Was an	24b. Were autopsy findings available
ec	has by	ig n			autopsy performed	prior to completion of cause of
=		Ö			1 Yes 2 1 1	
/ita	ysician: The is certificate his director, page	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)	1.7
7	Physi this c	2	1 Yes 2 No 1 Aunpatient 2 En/Outpatie	ent 3 UOA 4 Unursing Ho	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify)
Ē	ding Ph n. After th funeral	on:	27. Manner of Death 1 ★ Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	200. Describe flow in	july occurred
sio	Attending Physician: sr death. ector: After this certifics by the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be		28f Location (Street	and Number or Rural Route Number,
Division of	or At after d Direct in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, Sta	
	pital urs a sral [29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th accurred at the time, date and place	and due to the cause	(s) and manner as stated.
	To the Hospital or Attanowithin 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	thin the	Mec	29b. Signature and title of cartifier	29c. License number	29d. (Date signed (Month, Day, Year)
	8 4 8 4			D 53010		Tan 17, 2001,
	1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print		
	101		30. Name and address of person who completed cause of death (item 23a) (Type ANURA) MARCH	D 53910 RTHW859 HOSPIFA	RANDA	LLSTDWN MA
	\	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	eals 1	0) 1 20,0011	7,000
	Regisi		31. Date filed (Month, Day, Year) JAN 2 0 2004 32. Registrar's Signature	The Cartina		

MAN	_	1- For UNPEND ITEM 23a,	State of Mary &27 PER ME G82	land / Dep 7 1/28/04 _e	artme	nt of He	ealth ar Death	nd Me	ntal Hyg	giene Reg. No.	200			751
		Registrar 1. Decedent's Name (First, Middle, Last							. Date of Dea Month		Yee	ar l	ime of E	
Physic /Med		DENISE	HARRIS		,				Januar	y 14	, 2004	$1 \mid 16$	554	РМ
Exami	iner	4a. Fecility Name (If not institution, give		+		r, Town, or leverl	Location of	Death			County of D		10 le	
		Prince George's 5. Social Security Number 6. S		yrs. last birthday		er 1 Year	-Y If Under 24	4 Hrs. 8	Date of Birtl	h		Birthplace (Foreign
Funeral Director		1	□M 2□F	49 Yrs.	Months	Days	Hours	Min.	(Month, Day UG。 24	/, Year)		Country) P		
pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation							10d. In	side City	/ Limits
DESILITIOTE, INICITY ICIDIC 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 I emarked other than "natural", or items 23a or 28e-f show eny injury or other treumstic event, it a Madical Evanirar must be notified at	٥	,		•		NTC/TICNT							Yes	
the A	Director	DC NA 10e. Street and Number		W		NGTON ip Code				10g. Citiz	zen of What	Country?		
h with	O	5015 JAY	STREET				20019				IISA			
deat	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Dec			in? (Specif Puerto Ric	fy Yes or No- can, etc.)	. 1	4. Race - A		lian,	
or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give			2 XNo	Specity:				Specify: A	AFRICA	N	
hours fursi	ed by	3 Widowed 4 Divorced	Year or Dates:	16a, Dece	edent's Us	ual Occupa	ition			16b. Kir	And of Busine	MERIC ss/Industry		
in 72	Completed	(Specify only highest gra	Cotlege (1-4or 5+)	(Give	e kind of v	rork done d use retired,	uring most	of working						
d with giene	mo	Elementary/Secondary (0-12)	2		GRA	PHIC_	ARTIS	ST						
al Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle,	Maiden .	Sumame)			
y day	2	JAMES E.	HARRIS	1				LLA	MAE		LIAMS			
12 sh and 10 m		19a. Informant's Name/Relationship (Route Numbe					
1 and 1 and Health em 27		CAROLYN V. WILLIA 20a. Method of Disposition		Ob. Place of Disp	osition (A	ame of	REET #	7F30 / Dat	NW WA		cation - City		2000 tate)9
ages of of t: If it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif		cometery, cre			1	1 /00 /	0.4	ED A	31177 T31	17 A		
Description Description Department of mportant: If It ony injury or of		21. Signature of Funeral Service Lice		OUTHVIEW			s of Facility	1/22/	04	FRA	NKLIN	, VA		
		market	Mul		600	N 0	TT WOD	WY	LIE FU	NERA	L HOM	E PA		
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the	death. Do not er	nter the m	ode of dying	g, such as c	ardiac or	espiratory ar	Test, III	IURE,	MD Appl	oximate vai Betw	reen
Physician		disease or condition		ALCOHOLIS								Onsi	et and D	•ain
/Medica Examine		resulting in death)	Due to (or as a co											
LAUITITIC		Sequentially list conditions,	b. Due to (or as a co	onsequence of):										
uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
ou, be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):										
S 5 6	cal		d											
The Cords, F.O. BOX 68 The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Med	IF FEMALE:												
DOX ath cer attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim	Fetal death 3	□Ectopic	pregnancy				2	23d. Date of Month	Day	Y	ear
the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	e or death 5	CI OTHER!	specify/								
that the hold by detail	by Ph	Part II. Other significent conditions	contributing to death but n	ot resulting in the	underlying	g cause give	en in Part I.		23e. Did te	obacco u	se contribut	e to the cau	ise of de	eath?
ecords law requires as been sign						-			101	/es 2[□No 3□] Probably	4 <u>□</u> U	nknown
aw re	Completed								24a. Was		prior	autopsy fi to complet	ndings a	vailable use of
The law ate has page 2 s	E O								/ perfo	rmed? 2 ☐ No	deat	h? Yes 2□I		
VICIAN: The ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?				0.1		of Death (check only o	ne)				
OI VICE Physician: this certific ral director,	2	1 Yes 2 No	Hospital:	2XER/Outpatie			4 🗀 1401		e 5 Resid			Specify)		
Jing F Jing F After funer	ion	27. Manner of Death XXNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury		28c. Injury Work	k? Yes 2□N		.d. 20301100 1	iow injur	y ododirod			
VISION r Attending er death. rector: Afte by the fune	fical	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Injury	- At home, farm, s	street, fact				f. Location (r Rural Rou	te Numi	ber,
after I Dire	Certification:	4 Homicide	building, etc. (Specity)					City or Tov	vn, State,)			
To the Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1☐ Certifying P	hysician: To the best of n	ny knowledge, dea	ath occurr	ed at the tin	ne, date and	d place, an	d due to the	cause(s)	and manne	r as stated.	ause(s)	
To the H within 24 To the Fi complete	Medical	one)	and manner stated								e signed (M			
With To T	2	29b. Signature and title of certifier	111			O.C.					e signed (M Nuary			
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		30. Name and address of person who	KE MM	л (пет 23а) (Туре 1 3	u, erint) L1 Pe	nn St	reet,	Balt	imore,	Mar	yland	2120	1	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's		1	and to								
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neral ector	175-30-91	1	□M 257F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Bill (Month, Da	ay, Year)	9.	Country	e (State or Ford
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sand or must be extilled by Funeral Director	10e. Street and Num		LQ	FOI	rest I	10f. Zip	Code				10g Citis	zen of Wha	t Country	X
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Š	11. Marital Status		12. Was Decedent E Armed Forces?	- 0.5.	IS. V	f Yes, spec	eify Cubar	spanic Orig n, Mexican	, Puerto F	cify Yes or No lican, etc.)		14. Race - / Black, V	Amencan Vhite, etc	
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E	Elementary/Secon	dary (0-12)	College (1-4or 5-	+)										
පි	12				Dieta	ary C						alth (Care	
Be	17. Father's Name (F									(First, Middle	, Maiden .	Sumame)		
2	Samuel (C	Neigh	nly				Juli	.a	(u/k)		Shaf	fer	
	19a. Informant's Nan	me/Relationship (7	Гуре, Print)		19b. Mailing	g Address	(Street ar	nd Numbe	r or Rural	Route Numb	er, City or	Town, Sta	te, Zip Co	ide)
	Sandra Gor	crell - Da	aughter		1119	Wast	Jam	notte	vri 1 1/	a Road	Evr	soet I	1411	MD 210
	20a. Method of Dispo	sition		20b. Plac	e of Dispos	sition (Nam	ne of			ite		cation - City		
	1 Burial 2	Cremation 3√ □ Other (Specify	Removal from State	L	-				1/21	101	Tota	-aha	Down	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Yeer **Physician** Anna Josephine Hall January 15, 2004 11:25 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 27 Court Drive Joppa If Under 24 Hrs. Harford If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 💢 F Yrs Director 187-18-6610 Usuel Residence of Decedent 87 July 7, 1916 Pennsylvania permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 23s or 28s-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or flams 23a or 28a-f show 1 ☐ Yes 2 XNo Director Maryland Harford Joppa 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27 Court Drive 21085 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ٥ Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Staff Provider Mental Health Care 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margarete (nmn) Dominic (nmn) Conturso 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 27 Court Drive, Joppa, Maryland 21085 Joanne M. Velez - Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1. Burial 2 Cremetion 3 Removal from State
4 Degation 5 Other (Specify) Bel Air Mem. Gardens 1/20/04 Bel Air, Maryland ral Servi Licensee 22. Name and Address of Fecility McComas Funeral Home, P.A. 21. Signe 1317 Cokesbury Road, Abingdon, Maryland 21009 mil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner DISTASE Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed for use as the bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by pege 2 should be detact 1 Tes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 2 3 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Hesidence 6 □Other (Specify) 3 DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending al or Attendin s after death. i Director: Aft 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier We certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title use of death (Item 23a) (Type, Print) NO CURNER ROAD WHITE IM IRM.D. 31. Date filed (Month, Day, Year) 32. Registraris Signature State Registrar

DHMH 16 Rev 6/95

ORIGINAL

			For State Registrar	State of Marylar		artment rtificate			d Mer			2001	. 0105
	25		Decedent's Name (First, Middle, Last))		incate	OID	Calli	2	Date of Death	g. No.	2006	3. Time of Death
	Physici		Robert Harold H							Month anuary	Day	2004	10:00 AM
}	/Medic Examir		4a. Fecility Name (If not institution, give			4b. City, T	own, or L	ocation of De				ounty of Death	10.00 1
in the	- Admin		102 Juniper Drive					ırnie			1 .	nne Aru	nde1
	Funeral			7. Age (In yrs.		If Under 1	Year	If Under 24 H	Irs. 8.	Date of Birth (Month, Day,			place (State or Foreign
	Director			2M 2□F 82	Yrs.	Months	Days	Hours M	J.	uly 16	19	21 Ohi	O O
	and **		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation							
	fanyla faho	ō	MD Anne Arun										0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28s-	ect	10e. Street and Number	der G1	en Bur	10f. Zip (20de			10	- 0'1'-	(117)	
	with Sa or	Funeral Director	_			TOI. ZID		0.00				n of What Cour	ntry?
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ယ	r Her	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces?	1			anic Origin? Mexican, Pu	erto Rica	an, etc.)		Black, White,	
ğ	ral', o	þ	3XWidowed 4 ☐ Divorced	1X□Yes 2□No If Yes, Give 1942— Year or Dates.	46	1⊡Yes 27	No.	Specify:			S	pec <i>ify:</i> wh	ite
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2	of thin	du	Elementary/Secondary (0-12)	College (1-4or 5+)				ring most of v	WOIKING			C 11	
2	tited within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Evarifinar must be notified at		12		1011	ce Ofi						e of Ma	ryland
anc	be fi	Be	17. Father's Name (First, Middle, Last) Ralph Hershey							rst, Middle, M	aiden Su	imame)	
<u> </u>	hould d Me mark maric	ပ္		an Orient O	401 14 14			Sarah N					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a'f show any injury or other traumatic event, the Madical Evertimer must be notified at once.		19a. Informant's Name/Relationship (Ty) Mrs. Melinda Selan									own, State, Zip ryland	
<u>ة</u>	Heal Heal tem 2		20a. Method of Disposition	20b. F	lace of Dispos	sition (Name	e of	Laile,	Date			tion - City or To	
<u></u>	ages ant of it: If it		1 ØBurial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	natory or oth	er place)	Jar	3420				
altimore,	artme ortan injur		21. Signatura Fuer License		ryland							sville,	
ñ	De Period		Mark aix	mo/3/9	1	Secor	nd Av	enue S	S.W.	. Glen	Ruri	ral Hom nie, MD	e P.A. 21061
泰			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the deat								TIC, III	Approximate
	Physician		Immediate Cause (Final disease or condition		0. 1	Tie	mi.						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	mpu	VCI LO	70					
	Examiner		Sequentially list conditions	Due to (or as a conseq CORNOVA Due to (or as a conseq	irfery	- dis	seas	e					
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	and trans	cam	that initiated events cresulting in death) Last	diabete									
8760,	ate be executed hysicien and the burial-transit			Due to (or as a conseq									
687	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dlcal	d	hyperter	18190								
Box	eath certific attending p	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ncy						004		
	death a atte	Iclai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pred					230	. Date of delive Month	ry Day Year
J.	t the by the	hys	9 Unknown	9□ Unknown			,,				}		
	ires that the de signed by the a 1 be detached t	оу Р	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cau	ise given i	in Part I.		23e. Did toba	cco use	contribute to th	e cause of death?
S. C	w require been sig									1 🗆 Yes	2 🗆 N	lo 3 🗆 Proba	ably 4 🗹 Únknown
ပ္ပ	has be	ompleted								24a. Was an	2	4b. Were autor	sy findings available
r	, 42 O	Con								autopsy performe 1 ☐ Yes 2 €	d? No	death?	npletion of cause of
Vital Records,	iffic or,	Be	25. Was case referred to medical examiner?		1100			6. Place of D		eck only one)	37.0		
0	S S D	2	1 ☐ Yes 2 ☑ No		ER/Outpatient				Home	5 Aesidend	e 6 [Other (Specify)
	fter fter ine	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		: Injury at Work?		28d.	Describe how	injury od	ccurred	
UNISION	Attending r death. sctor: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	One Disease (Jalyan Aug		М		2 □No					
2	or A after Direction by	ertification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, o	office		28f. L	ocation (Stree City or Town, S	et and N State)	umber or Rural	Route Number,
	spital ours neral filled	O	29a, Certifier 1 Certifying Physi	ician: To the best of my kno	wledne death	occurred at	the time	date and plac	co and c	tuo to the saw	20(0) 00	d	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examin	er: On the basis of examinat and manner stated.	ion and/or inve	estigation, in	my opini	on, death occ	curred at	the time, date	and pla	ice, and due to	the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier			29c. t	icense nu	umber		29d	. Date si	gned (Month, E	Pay, Year)
	1		1/1/sm.0			De	055	931			1/1	5/04	
	10		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, P								
	V		8096 Edwin Kay		asodono	1	MP	211	120				
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registrar's Signar	пь	1000							

			i icasc	State of M								gible.	
			1 - State	State of W	ai yiai	•		e of De			eg. No. 2	004	01058
			Registrar 1. Decedent's Name (First, Middle, La	ist)				0, 50		2. Date of Dea	th		3. Time of Death
	Physici		Gertrude Li	llian Hun	hes					Januar \	Day 15.	2004	8:22 p ^M
	/Medic Examin		4a. Facility Name (If not institution, given				4b. City	Town, or Loc	ation of Death			unty of Death	,
			Greater Baltimo	re Medical	Cent	cer		Towson			I	Baltimo	re
П	Funeral			1 1 M 2 1 E		last birthday) Yrs.	If Unde Months		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign htry)
	Director		182-01-4366 Usual Residence of Decedent	''' 'X '' 9	<u> </u>	113.				Nov. 10	, 191	2 Penr	nsylvania
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
	Marie I	ctor	Maryland Baltimo	re		Lut	hervi	11e					1 ☐ Yes 2 ☐ X No
	or 28	Dire	10e. Street and Number				10f. Zi	Code		1	0g. Citizer	of What Cour	ntry?
	8 23a	Funeral Director	66 Belmore	-T	E	0 10		2109		- 7 V	U.S	.A. Race - Americ	
	item	-ru	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2 X	,	.5.	if Yes, spe	cify Cuban, M	lexican, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
2	urs af	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 No S	pecify:		Sp	ecity:	Jhite
	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usu	al Decupation	n most of work	ring	16b. Kind	of Business/In	dustry
7	ofthin 196.	mpie	Elementary/Secondary (0-12)	Cotlege (1-4or	5+)				g most of work	9			
7	iled w tygier her ti	S	12 17. Father's Name (First, Middle, Las.	21		Home	e Mak		Mother's Nam	e (First, Middle,		n Home	
2	d be finital h	Be	Christian	″ Henkel	1				Mary		ocks	manie)	
_	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the arth and Mental Hygiene. Other traumatic event, the Medical Examerations is could be notified at	ှင	19a. Informant's Name/Relationship			19b. Mailir	ng Addres			al Route Number		own, State, Zip	Code)
Ĕ	alth an 27 io		Ronald Huber	Son		66 B	elmor	e Road	Luth	nerville	. Mar	vland	21093
กั วั	s 1 a of Hear item		20a. Method of Disposition	70	20b. F	Place of Dispo						ion - City or To	
	Pages nent of ant; If it ury or o		1 🕅 Burial 2 □ Cremation 3 [`4 □ Donation 5 □ Other (Speci			oreland			1-19-	-2004	Parkv	ille. N	Maryland
Dalitallo	permit. Pages 1 an Department of Heal Important; If Item 2 any injury or other once.		21. Signature of Funeral Service Lice	nsee				nd Address of			-	1050 Yc	rk Road
	go = 9 a			gan	-							Towson,	Md.21204
			23a. Part 1 Enter the disease, or conshock, or heart failure. List only	one cause on each li	d the deat ine.	h. Do not ent	ter the mo	de of chying, su	ich as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		7417	1 >						-01231
à	Examiner		1	Due to (or as	a conseq	uence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence of):							
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,00	e exe	EX	resulting in death) Last	Due to (or as	a conseq	uence of):							
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0 40	ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancv					224	Data of dalling	
	atten atten i for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3	Ectopic p				230.	Date of delive Month	Day Year
;	oy the	hysi	1 ☐ Yes 2 ဩ No 9 ☐ Unknown	9□ Unknown									
v.	s tha	by P	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	ndertying (ause given in	Part I.	23e. Did tot	oacco use	contribute to th	ne cause of death?
cords,	aquire en siç buld b	ted								1 🗆 Ye	es 2□N	o 3 Prob	ably 4 DUnknown
ร	law ras be	Completed								24a. Was a autops	n 2	4b. Were auto	psy findings available appletion of cause of
<u> </u>	The cate h	Corr								perform	ned?	death?	
N I I	ician: sartific ector,	Be	25. Was case reterred to medical examiner?	Hospital:					Place of Deat	h (Check only on	ө)		
5	Phys this ral dir	2	1 Yes 2 No 27. Manner of Death	1 Inpatio		ER/Outpatien		OA Other: 4		me 5 Reside			"
5	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м	Work? 1 ☐ Yes		20d. Describe no	A HIJUIY OC	Zuneu	
NISTOIL NISTOIL	Atten r deal ector;	fica	3 Suicide 6 Could not b	28e. Place of Ini	ury - At h	ome, farm, str	eet, factor			28f. Location (St	reet and N	umber or Rura	l Route Number,
5	al or	Certification:	4 Homicide	building, et	ic. (Specif	у)				City or Towr	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 ☐ Certifying P	hysician: To the best miner: On the basis o	of my kno	wiedge, death	h occurred	at the time, d	ate and place,	and due to the ca	ause(s) and	d manner as st	ated.
	the H in 24 the F inplete	Medicai	one)	and manner st	ated.	mon and or m							
	To To con	-	29b. Signature and title of certifier	Hollichy	Dhu	SICIPI	29	c. License nui	3647	> 2	ed. Date si	gned (Month,) (on (/
	2		200	gompleted as	tont /	220\7	Deight	(-)			an.	(0	200 4
	9		30. Name and address of person who	500 Protect cause of c			C(Y Ju	51V	U 30.	3 Bal	H.M	the o	11239
J	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	iture	Qr.			1			
	Registr	ar	0.0	2001		10 0	0.0						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** PM 6 HOY JANUALY 410 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNG HOPKING HOSPITAL MD Baltimore City BALTIMORE If Under 1 Year II Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea
March 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1932 (Year) Birthplace (State or Foreign Country) 1 □ M 2 💯 F 216-28-4124 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at or 28a-f ehov Linthicum Anne Arundel 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 407 West Maple Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant U.S. Government and Mental Hygie 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 Ie marked other eny injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Harry R. Chaney Roberta Mitchell 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mr. Carroll Edward Hoy /Husband 407 West Maple Road Linthicum, MD 21090 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jaffate21 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2004 Glen Haven Memorial Park Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature Alf Ineral Santice Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MU1220 1 Second Avenue SW Glen Burnie, MD 21061 Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MYELOGENOUS ACUTE LEUKEWIA TRANSFORMATION TWO DAYS resulting in death) /Medical Due to (or as a consequence of) Examiner GIY MONTHS MYELODYSPLASTIC SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time ol death Month Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CROHN'S DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been EMPHY GEMA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signal@e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 MD JANUARY 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. GAVIN THE JOHNS HOPKINS HOSPITAL HAMILTON GOO N. WOLFE ST. BALTIMORE MD 21287 31. Date liled (Month, Day, Year) JAN 2 32, Registrar's Signature State 2004 Registrar

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Ma	aryland		artmen rtificate				ental Hy	/giene	20	004	01060
	· ·		1. Decedent's Name (First, Middle, L	ast)							2. Date of D Month	eath Da	v	Year	3. Time of Death
	Physici /Medio		Alice				Har	mon			Januar	y 16		004	6:45A M
7	Examir		4a. Fecility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location of	of Death		4c.	. County	of Death	
			362 Drew Street				Ва	1tim	ore					N	A
	Funeral		Social Security Number 6.		e (In yrs. la	ast birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth		9. Birthp	place (State or Foreign
	Director		212-46-0827	1□M 2 Q F	57	7 Yrs.	Months	Days	Hours	Min.	Nov. 2	22 19	46	West	Virginia
	P.		Usual Residence of Decedent												
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation							1	10d. Inside City Limits
	B Ma	ct	Maryland NA	A	I	Baltim	ore								1 Yes 2 No
	th th or 28	le e	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of \	What Cour	ntry?
	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show Alcal Examiner must be notified at	by Funeral Director	362 Drew Street				2	1224					U	J.S.A	•
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	0-			can Indian,
9	after or Its	£	1 Never Married 2 Married		No		_				nicali, etc.)			ck, White,	
8	ours and	<u>5</u>	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			1 ☐ Yes 2	ZENO	Specity:				Specify	Whi	te
215-0036	72 h	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of worki	20	16b. K	ind of B	usiness/In	dustry
2	B. B.	헏	Elementary/Secondary (0-12)	College (1-4or !	5+)	life.	DO NOT us	e retired)	COI WORK	,9				
21	arth Brith	5	8	NA		Hom	e Mak	er				0	wn H	lome	
b	al Hy loth	Be (17. Father's Name (First, Middle, La.	st)					18. Mothe	er's Name	(First, Middle	e, Maiden	Suman	ne)	
/la	Went Went wrkac	2	Harold		Chaf	ins			Eff	ie			Wa	are	
Maryland	and and summer		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numi	ber, City o	or Town,	State, Zip	Code)
	and alth		Joey Breiannis	(Daughter)	362	Drew :	Stre	et Ba	ltim	ore, M	arv1	and	2122	4
ğ	of He itan		20a. Method of Disposition		20b. Pt	lace of Dispo	sition (Nan	ne of	- 1		ate				own, State
Ĕ	Page ent c nt: ff ry or		1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec			ık Lawı		,		17,2	-	Bali	timo	re. 1	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Lic		0	2	. Name an	d Addres				1201	-	10, 1	aryrana
ä	Depa Impo any is		Mark (10	housenal	4,-		W. Dabi	rows	ki-Ch -11- ∧	ojna	cki Fu	nera.	l Ho	mes]	P.A.
			23a Part1. Enter the disease, or co	mplications that caused	the death	. Do not ent	er the mode	e of dyin	GLK A g, such as	cardiac c	Baltim r respiratory	ore, I arrest,	Mary	Land	Approximate
			shock, or heart failure. List on Immediate Cause (Final	. /						,			·~		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. MET	AS	SALI	<u> </u>	KI	DIVE	= Y	CAI	VC			
	Examiner			Due to (or as	e consequ	rence or):									
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):									
	nsit	Examiner	Cause (Disease or injury			,									
	xecu and	xar	that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):									
Box 68760	be e iciar buri	cal													
387	phys the		100	_ d											
×	ding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnat	ncv									
Bo	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3[Ectopic pro							te of delive onth	ory Day Year
P.O.	the de	Physiclan/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or de	atn 5L	Other (sp	өспу)							
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death h	ut not resu	Iting in the U	nderlvina c	auco arve	n in Part I		23e Did	tohaccou	ISA CONT	obute to the	ne cause of death?
Records,	uires tha signed I d be det	Completed by	CANCER O			Veck		adoo give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2			pably 4 Dunknown
Ö	w require been sig	etec	CHITICOR	11000	7 1	·	_				-	,,,,,			
ec	alaw nash e 2 s	du									24a. Wa auto	psy	1	prior to con	psy findings available mpletion of cause of
=	The cate pag	ပ္ပ									1 ☐ Yes	formed? 2 ☐ No		death? 1 🗌 Yes	2 No
Vital	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)			
of \	hyai his c	ဥ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		ER/Outpatier			4 ⊔ Nu	irsing Hor	ne 5 Res	idence	6 □Oth	er (Specif	y)
u	ng P	:io	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	2	8c. Injury Work	at ?	2	28d. Describe	how injur	y occurr	red	
Sio	Attanding ir death. ector: After by the fune	atl	2 Accident investigat				М	10,	Yes 2□	No					
Division	r Att	ij	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At hor	me, farm, str	eet, factory	, office		2	28f. Location City or To	(Street an	d Numb	er or Rura	I Route Number,
	rs aff	Certification:													
/	To the Hospital or Attanding Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 11 Certifying I	Physician: To the best eminer: On the basis o	of my know	wledge, deat	n occurred a	at the tim	e, date an	d place, a	and due to the	cause(s)	and ma	anner as si	tated.
	tha H in 24 tha F iplete	edi	one)	and manner st	ated.						at the three	, date and	r place, c	and 000 to	7 (110 02030(3)
	To I To I	Σ	29b. Signature and title of certifier	0		JA V	1		number	_		29d. Dat	e signe	d (Month,	Day, Year)
	7		Alleneer	J. JAnles	-	M.L	1. 1.	02	92	8	3	Jan	uar	y 16,	2004
1	/		30. Name and address of person wh		leath (Item	23а) (Туре,									
(Jimmy D. Taylor	M.D4940 Eas	stern	Ave.	Balti	more	Ma:	rylaı	nd 2122	24			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ture			,	,					
	Registi	ar	JAN 2	2004	Elkar.	A.	(2004)	Sales Sept.							

			1 - For State Ragistrar	State of M	Marylar		artment rtificate					jiene lag. No.	200		01	161
	Physici	an	1. Decedent's Name (First, Middle, La	•						2.	. Date of Dea Month			ar	3. Time of	_
	/Medic Examir	cal	Christine League 1 4a. Fecility Name (If not institution, give		er)		4b. City.	Town, or	Location o		Januar		County of D		1255	PM
	Exami	lei	Union Memorial Ho		,			timo					N/A			
	Funeral Director		5. Social Security Number 6. S 212-01-1693	ex 7.7 ☐ M 2 X XF	Age (In yrs. 91	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	Date of Birth (Month, Day arch 31	, Yeer)		Count	ece (State d ry) ginia	r Foreign
4	T		Usual Residence of Decedent				1			Ţ,ŗç	arcii 5	L, L	714			
	Aarylar f show	ō	Maryland N/A			ty, Town or Lo 1timor								10	d. Inside Ci	*
	r 28a-	Irect	10e. Street and Number				10f. Zip	Code			1	l0g. Citiz	zen of Wha	t Count		
	23a o	a D	830 W. 40th St.				212	11				Uni	ited S	Stat	es	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturs!", or Items 23e or 28e-f show any injury or other traumatic event, tra Medical Eracit or transitive rivillia.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Dates	s? XNo		Was Deced If Yes, spec 1 Yes 2	ify Cuba	spanic Orig n, Mexican Specify:	i, Puerto Ric	y Yes or No- an, etc.)		I4. Race - A Black, V Specify:		itc.	
2	72 ho	eted	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usua kind of wor	l Occupa	ition urina most	t of working		16b. Kir	nd of Busine	ess/Ind	ustry	
12	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.				t of working			b.			
<u>Б</u>	Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			1	HOM	emak	18. Mothe		First, Middle, I	Maiden .				
ylar	Menta Menta Marked Marked	ToE	Howard Alton Leag								zabeth		`			
altimore, Maryland 21215-0036	od 2 sh lith and 27 is m traum		19a. Informant's Name/Relationship (Ascanio Boccutti/							erorRumalR a Ave	oute Number Tows	; City or SON ,		e, <i>Zip</i> (212		
Jre,	of Hea		20a. Method of Disposition		1 -	Place of Dispo	sition (Nam	e of	- 1	Date	-		cation - City	or Tov	vn, Stete	
E E	ment tant: If tant: If		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	1)	Dru	id Rid	ge Ce	mete	ry J						Mary	land
Ba	Depar Impor any in		21. Signature of Funeral Service Licer	All			65	UU Y	ork b	Ka.	ld Fun Baltim	ore.	L Home	212	nc. 212	
			23a. Part1. Enter the disease, or com- chock, or heart failure. List only Immediate Cause (Final	plications that caus one cause on each	ed the deat line.	h. Do not ent	er the mode	of dying	, such as	cardiac or re	espiratory arre	est,			Approximate Interval Bet Onset and D	ween
	Physician /Medical		disease or condition resulting in death)	a. Sepsis Due lo (or a	S as a conseq	uence of):								te	en hoc	275
Ť.	Examiner	L	Sequentially list conditions,	b		all's							-			
	uted I Insit	Examiner	Sequentially list conditions, and leading to make the cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence of]:										
o`	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or a	is a conseq	uence of):										
8760	cate be ohysici the bu	dical		d										-		
9	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna	incy			- 1 1111104 ()			2	3d. Date of	deliver	v	
.O. Box	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant 9□Unknown	at time of d		Ectopic pre Other (spe				-V44		Month			'ear
0	res that the de igned by the a be detached to	by Ph	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco us	e contribut	e to the	cause of de	eath?
ords	w require been sig should by										1 □ Ye	s 2	3□	Proba	bly 4 □U	nknown
Division of Vital Records,	aw Is t	Completed						<u>-</u>			24a. Was a autops	v !	prior	to com	sy findings a pletion of ca	available
a		e Col	25. Was case referred to medical							/ D		No No	death 1 🔲 \	'es 2	(A)	
>	Physician: r this certific ral director,	0 B	examiner?	Hospital:	tient 2 🗌	ER/Outpatien	t 3 DOA	Othe			theck only one 5 □ Reside		□Other (S	ipecify)		-
0	ing Ph ofter th	on; T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of In (Month, D		28b. Time of Injury	28	c. Injury Work	at ?	28d	l. Describe ho	w injury	occurred	,,,,,		
ISIO	I or Attending P after death. I Director: After t d in by the funera	ficati	2 Accident investigation 3 Suicide 6 Could not be		niurv - At ho	ome, farm, stre	M eet factory		es 2□N		Location (St	reet and	Number or	Rural	Route Numl	her
2	spital or A ours after neral Dire- filled in by	Certification;	4 ☐ Homicide determined	building,	elc. (Specif)	y)	501, 140101 <i>y</i> ,	Omoo		1	City or Town	, State)	110111201 01	710707	10010 / 10///1	761,
/	Fur h	edical (29a. Certifier (Check only one) 2 Medical Exam	ysicien: To the bes niner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred a restigation,	it lhe time in my op	e, date and inion, deatl	d place, and h occurred a	due to the ca at the time, da	use(s) a ate and p	and manner place, and c	as stat	led. he cause(s)	
	To the within 2 To the complet	Ň	29b. Signature and title of certifier				29c.	License	number		25	9d. Date	signed (Mo	onth, De	ey, Year)	
	i()		Meschlie					243	8946	PQ			1/13/	04		
	10		30. Name and address of person who catherine Meschler				167	anı	= ()		L. D.	F	Ra	lhom	nne Mi	סובוב (
	Sta Registr		31. Date filed (Month, Day, Year)	32. Régis	strar's Signa	ture	Jack S	,		ar restor	1		4) 00		J. C. 11-6	- Alvio

ì			For State Registrar	State of Maryland	•	nt of Health and te of Death		iene 19. No. 2 () () (. 01062
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last, Ving In Ca. 4a. Facility-Name (If not institution, give	Estelle	Hawkir.	7 <i>5</i> y, Town, or Location of Dea	2. Date of Death Month January	Day Year 11, 2004	3. Time of Death 11:09 A M
(9) 	Funeral Director		019 00 1110			odlawn er 1 Year If Under 24 Hr s Days Hours Mir		Baltimon Year) 9. Bin	ce hplace (State or Foreign buntry) W Jersey
	e Maryland Sa-f ahow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltim		Town of Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23s or 28s-f show Finust be notified at	Funeral Director	10e. Street and Number 6806 Town 6	rook Driv	CAPAD 0	ip Code 21207 edent of Hispanic Origin?		og. Citizen of What Co	
0-00-0	72 hours after d natural', or Iten	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 PNo If Yes, Give Year or Dates:	1 ☐ Yes			Black, Whit	ack
-61717	within sne.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v jife. DO NOT	vork done during most of w use retired) DRIVER	orking	School	Industry
ryland	should be filed of the standard Mental Hygie marked other famatic event, If	To Be	17. Father's Name (First, Middle, Last) SCIE COLLER 19a., Informant's Name/Relationship (T)	rne Print)	19h Mailing Addre	18. Mother's Na Anna ss (Street and Number or F	Ame (First, Middle, M	·	Zin Code)
ore, ma	1 and 2 s Health ar hm 27 is ther treu		Reyon tig Hawl 20a. Method of Disposition 1 Method of Disposition 3 Greenation 3 Greenation 3 Greenation 3	Kins-daughter	(IOE. 13) lace of Disposition (Nemetery, crematory of	8th St. Apt.	4A Newy	20c. Location - City or	0637
Bairimo	permil. Pages Department of I Important: If its any injury or o		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	IVII	22. Name	emetery 1-19 and Address of Facility	-04 L	Acc galla	nh 21329
	Physician /Medical		23a. Port of the disease, or comp should be a comparable of the comparable of the comparable of the comparable of the condition resulting in death)	ications that caused the death ne cause on each line. Hypwlewive te to (or as a consequence)	atheroscler				Approximate Interval Between Onset and Death
,007s	ate be executed hysicien and he burial-transit	Ical Examiner	if any, leading to minediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence. Due to (or as a consequence)					
O. Box 6	The law requires that the death centificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 M Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic			23d. Date of de Month	livery Day Year
ecords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	cause given in Part I.	1	pacco use contribute to es 2 □ No 3 □ Pr	V
r		Completed					24a. Was a autops perform 1 X Yes 2	y prior to	utopsy findings available completion of cause of
on of Vital	(ospitel or Attending Physicien: The Phous after death. Nours after death. Nanerel Director: After this certificate by filled in by the funeral director, pag	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input (Month, Day Year)	ER/Outpatient 3 [[28b. Time of Injury M	100		·	cify) at scene
Division	Nospitel or Attandir At hours after death. • Funerel Director: Af etely filled in by the fur	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, facto	ory, office	28f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,
1	Z VIL V	Medical	(Check only 2. Medical Exam one)	sician: To the best of my kno- iner: On the basis of examinal and manner stated.	tion and/or investigation	on, in my opinion, death oc	curred at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the complete	×		v.)		9c. License number O.C.M.		od. Date signed (Mont January 12,	
		ate	30. Name and address of person who come and address of person who come are also as a second and		,111 P	enn Street, I	Baltimore	, Maryland	21201
	Regist		JAN &	- Comment					

		- State Unpend Item # Registrar Decedent's Name (First, Middle, Lasi			- Cei	lilica	le oi L	Jean		2. Date of De		0.		3. Time of Deati
Physician	1	LINDA CORNE		Z.E.						Month Januar	D	ay .3. 2	Year 1004	11:15 A
/Medical Examiner		a. Facility Name (If not institution, give				4b. City	, Town, or	Location of		variat	-	c. County		111:13 A
		21002 West Libert	y Road					е На					ltimo	
Funeral Director		5. Social Security Number 6. Se 212–52–9495	7. Ag	e (In yrs. 48	last birthday) Yrs.	Months	or 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da July 12	th y Year	955	9. Birthp	place (State or Fore htm) YLand
rector		Usual Residence of Decedent												/
whow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Lim 1 ☐ Yes 2 📉
be natified at		Maryland Baltimor	<u> </u>	1	White_	7					10- 0	isi 4 1	***	
be or 2		10e. Street and Number 21002 West Liber	tr Dood			10r. Z	ip Code	21161			10g. C		What Cour $\mathrm{S}.\mathrm{A}.$	iuy r
r Items 23e	5	11. Marital Status	12. Was Decedent	Ever in U	J.S. 13. \	Was Dec				cify Yes or No Rican, etc.))-	14. Rac	e - Americ	an Indian,
o, a	2	1 Never Married 2 Married 3 Widowed 4 MDivorced	Armed Forces? 1 ☐ Yes 2 ☑ ! If Yes, Give X Year or Dates:	No			ecny Cuba 2∭ No	Specify:	, Puerto I	rican, etc.)		Specify	ck, White, /: Wh	etc. ite
d other than "nature event, the Wadral B		15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	dent's Us	ual Occupa	ation	of working	na	16b.	Kind of Bu	usiness/Ind	dustry
mpk		Elementary/Secondary (0-12)	College (1-4or 5		Regis			furing most		3		Med:	ical	
Co nt.	3	17. Father's Name (First, Middle, Last)	5+ years	3	Kegra	rere	d Nui		r's Name	(First, Middle	. Maide			
item 27 is marked other than "nature other traumatic event, the Marked other traumatic event, the Marked To Be Completed		William Burgess	Cornell.	Jr				Kathr		Harla			ffith	L
ls marked other than sumatic event, the M To Be Comp	J	19a. Informant's Name/Relationship (T)				ng Addras				l Route Numb	er, City			
n 27 i		William B. Cornel	, III (b		-			oad		imore,		-		
or oth	1	20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ F	Removal from State	'	Place of Dispo cemetery, cren	natory or	other place			ate			City or To	
lury .		* 4 □ Donation 5 □ Other (Specify)		Gre	een Mou	int (Cremat		1–16					Maryland
Department of nearth at Important: If item 27 is any injury or other traugines.		21. Signature of Funeral Service Licens Service J. Fen	cim		N N	litch 6500	e11-V Yorl	Viedet Roac	fe1d 1 Ba	Funera altimor	1 Н е,	ome, Mary	Inc. land	21212
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sician ledical		Immediate Cause (Final disease or condition resulting in death)	Fatty L											
miner			Due to (or as	a consec	quence of):									
je je		Sequentially list conditions, if any, leading to immediate	Due to (or as	a consec	quence of):									
an and ial-transit Examlner		Cause (Disease or injury that initiated events	o											
		resulting in death) Last	Due to (or as	a consec	quence of):								- #	
physicie as the bu edical			j										-	
for use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome									23d. Dat	e of delive	rv
d by the attending letached for use a Physician/M		in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic Other (s	pregnancy specify)					Mo		Day Year
detached detached		Part II. Other significant conditions co	ntributing to death b	ut not res	sulting in the ur	nderlying	CAUSA DIVE	n in Part I		23e. Did t	obacco	use contr	ribute to th	e cause of death
5 8 2	ì	Chronic alcoholis	_		-	,	3			10	Yes 2	2 □ No	3 Prob	ably 4 Unkn
should should										24a. Was	an	24b. \	Vere auto	psy findings avail
cate has been s page 2 should Completed	-									autor perfo	rmed?	1 8	prior to con leath?	npletion of cause 2□ No
is certificate hadirector, page)	25. Was case referred to medical						26. Place	of Death	Check only	-		9.00	
€ = □	2	1 165 2 100			ER/Outpatien			4 🗀 1401:		ne 5 ☐ Resi				,at scen
fter iner		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	м	28c. Injury Work	at ⊲? ∕es 2 □ N		8d. Describe	how inju	iry occurr	ed	
al Director: After led in by the funeral Certification:		2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At h	ome, farm, str			105 Z [] N		8f. Location (Street a	nd Numb	er or Rura	l Route Number,
d in b		4 Homicide	building, et	c. (Speci	fy)		,,			City or To	wn, Stat	e)		
To the Funeral Director: A completely filled in by the tr	t	(Check only one)	ner: On the basis of and manner sta	examina	wiedys, death ation and/or inv	vestigatio	d at the tim n, in my op	s, data and inion, death	i piace, a h occurre	nd due to the id at the time,	date ar	o) and ma id place, a	iner as st and due to	ated. the cause(s)
To the	-	29b. Signature and title of certifier				25	c. License				29d. D	ate signed	(Month, I	Day, Year)
-		1 1 1	VIV				0.	C.M.E	•		Jar	uary	14.	2004
		/ Med Lio IA	/ King	men.1.		-						_	/	

			For State Registrar	State of M	aryland .	/ Depa	artmen rtificate	t of H	ealth a Death	and M		Reg. N		004	Q 1	06
š	Physicia /Medic	_	1. Decedent's Neme <i>(First, Middle, Las</i> Sidney)	C.	•	H	lodge	es,	Sr.	2. Date of De Month Jan.		ay 20(Yeer)4	3. Time o	
	Examin		4a. Fecility Name (If not institution, give Civista Medica	1 Center	e (In yrs. last	t histhday	4b. City, La I	Plat	Location of a		8. Date of Bit	C	c. Count har	1	plece (State	or Foreign
	Funeral Director		5. Social Security Number 409-28-6764 Usuaf Residence of Decedent	OMM 2□F	83	Yrs.	Months	Days	Hours	Min.	(Month, Di 09/21/	ay, Year)) 	Cou	ntry)	or roraigi
th the Maryland	or 28a-f ehow e notified at	Olrector	10a. State 10b. County Maryland Charles 10e. Street and Number		10c. City, T Wald	own or Lo	101. Zip	Code 206	.01			10g. C	itizen of	What Cou USA		Dity Limits
. I.Z. I.DUU.SO within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show stripting or other traumatic event, the Madical Extendible must be notified at ance.	Completed by Funeral Director	70 Village Drive 11. Marital Status 1 Never Married 2 Married 3XXVidowed 4 Divorced	12. Was Decedent Armed Forces? 1% Yes 2 [If Yes, Give Year or Dates:		13.	Was Deced	lent of Hi			ecify Yes or No Rican, etc.)	D-		ce - Ameri ck, White,	can Indian, etc. White	
d Z Z D-0050 filed within 72 hours af	Hygiene. other then "natur ent, the Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) 5 College (1-4or		(Give	dent's Usua kind of wor DO NOT us hool	rk done d se retired	tu <i>ring m</i> os) :he r				Edu	oatic		
Maryland od 2 should be file	and Mental Hygiene. is marked other than reumatic event, the M	To Be (17. Father's Name (First, Middle, Last) Hugh Ernest Hodg	,		10h Maili	o = Address	/Street	S	ilvi	e (First, Middle a Sharp ral Route Numb				n Codol	
2 P	Health and em 27 is n ither treun		19a. Informant's Name/Relationship (7 Sidney C. Hodges, 20a. Method of Disposition			3723	River	sed	e Dr	.,La	ke Oswe	go,	OR	97034		
Pages	Department of P Important: If ite any injury or of once.		1 Burial 2X Cremation 3 Cremat)	1	as Cr	osition (Nameratory or o	ry	J	an.1	5,2004	Edg	ewat	er, M	laryla	
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\/\	ysician Medical		23a. Part f. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	d the death.	Keno	ter the mod	e of dyin	g, such as	cardiac	or respiratory a	errest,			Approxima Interval Be Onset and	tween Death
death certificate be executed	attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequent		50 ps	ζ							Don't S	
nat the death certific	ned by the attending p detached for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	⊒Ectopic pr □ Other (sp							ate of deliv	ery Day	Year
quires that	50.00	by	Part II. Dther significent conditions o	ontributing to death t	out not resultin	ng in the u	inderlying c	ause give	en in Part I	l.					the cause of	1
I RECORDS, P.O.: The law requires that the	h. After this certificate has been si funeral director, page 2 should I	Completed									24a. Was auto perfi 1 \(\text{Yes}			Were autoprior to codeath?	opsy findings ompletion of 2 \(\text{No} \)	s available cause of
OI VII DI Physician: T	nis centif I directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2□EP	VOutpatie			er: 4 □ N		th <i>(Check only</i> ome 5 🗌 Res		6 🗆 Otl	her (Speci	(y)	
= E	death. ctor: After th / the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			8b. Time o Infury	М		/at k? Yes 2□	No	28d. Describe					
0	fter Dire		4 Homicide determined	building, e	tc. (Specify)						28f. Location City or To	wn, Sta	te)			mber,
To the Hospital	within 24 hours a To the Funeral C completely filled	edical		ysicien: To the best siner: On the basis of and manner s	of examination											(s)
Tot	To t	×	29b. Signature and fitte of certifier)			D	- 27	348			29d. D	ate signe	ed (Month,	Day, Year)	
- V	\mathcal{I}		30. Name and address of erson who Howard M. Haft	MD 1207	0 01d	Lin		nte	r St	e 10	00 Wal	dor	f,	MD 2	0602	
8	Sta Registr		31. Date fifed (Month, Day, Year)	32. Regist	rar's Signatur	3	mule	J.								

		,	For State Registrar		State	of Mary	yland /		rtmen <i>tificat</i>			ınd M	lental		ene 2 (104	01065	5
			1. Decedent's Name (F	First, Middle, La	st)								2. Date o		Day	Year	3. Time of Death	
	Physicia /Medic		He1	en L.	Jones								Jan.	15,	2004	1001	5:00 A ^M	
200	Examin	er	4a. Facility Name (If no			ımber)			4b. City,	Town, or I	Location o	f Death			4c. County	of Death		
			26 Cedar Ki			- A //		1-46-41-11	Co If Under		svill If Under 2			(D' ab		Baltin		_
	Funeral Director		5. Social Security Num 219-10-096		1 M 2 √ F		n yrs. last b 90	Yrs.	Months	Days	Hours	Min.	8. Date of				lace (State or Foreign	1
		1	Usual Residence of De				70						Dec.	14	1913	De	laware	_
	yland			0b. County		10	Oc. City, To									1	0d. Inside City Limits	
	a-f s	Director	MD	Baltimo	re		Coc	keys	ville								1 ☐ Yes 2 No	
	or 28	Oire	10e. Street and Number	er					10f. Zip	Code				100	g. Citizen of	What Cour	itry?	
	ath w	ra	26 Cedar	^ Knoll	T .					2103					US			
36	permit. Pages 1 and 2 should be tited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2) No ive	erini U.S.	1	Vas Deced fYes, sped I⊡Yes	cify Cuban	Specify:	in? (Spe , Puerto	ecify Yes o Rican, etc.	r No-)		ce - Americ ck, White, y:		
21215-0036	2 hou	ted	15	5. Decedent's E	ducation	-	16		lent's Usua					16	6b. Kind of B	usiness/Inc	dustry	-
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Maryland	12 sh h and 7 Is m		19a. Informant's Name				19								City or Town,	- 88	Code)	
	1 and Healt am 2 ther		Mary M. 20a. Method of Dispos		riend		20b. Place	of Dispo	sition (Nan	ne of			•		MD 21 oc. Location -		wn. State	_
Baltimore,	ages nt of t: If it		1 XBurial 2 🗆 C	Cremation 3		State	cemet Evero	ery, cren	natory or o	ther place	·	1/19°						
Ħ	artme artme ortan injury		° 4 Donation 5 (1-1-1-1	1 . 1	Lverg	22	. Name an	d Address	of Facility	,			inksb			_
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	**		23a. Part1. Enter the shock, or heart			cause the	a death. Do	not ent	er the mod	e of dying	, such as	cardiac o	r respirato	ry arres	t,	13 21	Approximate Interval Between	
	Physician	5	Immediate Cause (Pir disease or condition			100	REGROV										Onset and Death	
	/Medical		resulting in death)		a. Du to		onsequence			- /10					-			_
į,	Examiner		Sequentially list condit	tions.	b		MENT											
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	and I-tran	xam	that initiated events resulting in death) Las		C. Due to		DER LE		ο _M									
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687	phys phys s the	edical			_ d													-
Вох	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, or										23d. Da	te of delive	ry	
m.	death e atte id for	cla	in the past 12 mo 1 □ Yes 2 🔯 N	onths?	4☐ Preg	nant at tim	Fetal deat e ol death		Ectopic pr Other (sp					_	Мо	nth	Day Year	
Ö.	at the by the tache	hys	9 □ Unknown		9□ Unkr	nown												_
s, P	es be	by F	Part II. Other significa	int conditions	contributing to	death but n	ot resulting	in the ur	nderlying c	ause giver	n in Part I.				_		e cause of death?	
Vital Records,	w requir been si should	Completed											1	☐ Yes	2 No	3 Prob	ably 4 Unknown	_
ec	has be	nple											a	Vas an utopsy		prior to cor	osy lindings available inpletion of cause of	
= H		Con											1 🗆 Y	erforme s 2		death?	2□ No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:							of Death	(Check o	nly one)				_
of	Phys this al dii	-T	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date	Inpatient of Injury	2 ER/C	utpatien Time of		A Other	4 🗆 Nur				injury occur		')	_
L O	ling After fune	ton	1 🖪 Natural	5 Pending investigation	(Mor	nth, Day Ye	ear)	Injury	м	Work?	es 2⊡N		.00. Desci	DO HOW	inquiry occurr	90		
Division	Attending r death. ector: After by the fune	fica		6 Could not b	e 28e. Plac	e of Injury	- At home,	arm, stre	et, factory							er or Rura	Route Number,	_
ă	5 # # E	Certification:	4 Homicide		build	ding, etc. (8	Specify)						City of	Town,	State)			
-/	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 15 (Check only one)	K Certifying Ph ☐ Medical Exar	niner: On the l	e best of m basis of ex- nner stated	amination a	je, death nd/or inv	occurred estigation,	at the time in my opi	e, date and nion, deat	place, a	and due to ed at the ti	the caus	se(s) and ma	inner as st and due to	ated. the cause(s)	
	To the vithin 2 To the comple	Me	29b. Signature and title	e of certifier	1	20			1	. License				29d	. Date signe	d (Month, I	Day, Year)	_
)	1		> //	Nels	4 X	ale	110			058	656	2		J	AN. 15	, 200	4	
•	1/		30. Name and address						·									
			Dr. Mark S		54 Scot	t Ada Registrar's		d Su	ite :	202	Cocl	keys	ville	, MI	2113	0		
1	Sta Registr		31. Date filed (Manth.	2 0 200	4 Sea	ASS.		free	E									

			For State Registrar	State of Maryland / Depa		•	ne 2004 ninss
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	Jones		2. Date of Death Month	Day Year 3. Time of Death
	Examir Funeral Director	ner	5. Social Security Number 6. Sec	2015tel	4b. City, Town, or Location of Death By Houve If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
de la la la la la la la la la la la la la	<u> </u>	Director	Usual Residence of Decedent 10a. State	10c. City, Town or Lo BALTIMOR			10d. Inside City Limits 1 🖾 Yes 2 □ No Citizen of What Country?
336	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ahow valcal Eparting Index Contilled at	by Funeral Di	827 N ARLINGTON 11. Marital Status 1 Never Married 2 Married 3 🛣 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?	21217 Nas Decedent of Hispanic Origin? (Sr f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK
Maryland 21215-0036	d within 72 giene. ir than "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation 16a. Decec (Give life. L	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ESTIC	king	b. Kind of Business/Industry HOME CARE
Marylanc	12 should be h and Mental 7 Is marked o traumatic eve	To Be	17. Father's Name (First, Middle, Last) PHILMORE JONES 19a. Informant's Name/Relationship (Ty		ELLA I	ral Route Number, Ci	ity or Town, State, Zip Code)
Baltimore, I	ages 1 an ent of Heali nt: If item 2 y or other		Janet Sells/Niece 20a. Method of Disposition 1 Burial 2 A Cremation 3 B 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Licensi	20b. Place of Dispo cemetery, cren METRO CF	REMATORY 01-19	Date 200	and 21213 c. Location - City or Town, State ALTIMORE, MARYLAND
Ra	permit. F Departme Importar any injur		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do not enter	. Name and Address of Facility LLLIAM C BROWN COI 206 W NORTH AVENUI ar the mode of dying, such as cardiac	3	Approximate Interval Between Onset and Death
S.	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	CER		6 mushs
8760,	ate be executed hysician and the burial-transit	cal Examin	cause. Enter Underlying Cause (Lisases or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
P.O. BOX 68	that the death certificate to by the attending physic detached for use as the b	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	The law requires that the the has been signed by though 2 should be detached.	þ	Part II. Other significant conditions con	ptributing to death but not resulting in the un	Aurtie		co use contribute to the cause of death? 2 \(\sum No 3 \sup \text{Probably 4 \(\mathbb{P} \) Onknown
itai Kec		e Completed	25. Was case referred to medical		STE MUSIS 26. Place of Deal	24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Division of Vital Records,	Ø ≥ 5	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	lospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how in	
IAIN /	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	edical Certifi	4 Homicide determined 29a. Certifier (Check only 2 Medical Exemination)	28e. Place of Injury - At home, farm, stre building, etc. (Specify) sicien: To the best of my knowledge, death ner: On the basis of examination and/or inv	occurred at the time, date and place,	City or Town, St	e(s) and manner as stated.
	To the within 2 To the I complete	Med	29b. Signature and title of certifier Anary Mai	and manner stated.	29c. License number D 00 156 93		Date signed (Month, Day, Year)
46	Sta Registr		30. Name and address of person who co	Impleted cause of death (Item 23a) (Type, I	Secours Hispto	of Bulti	MUTE MY 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** JOHNSON JAMES 3:44 PM 17 2004 January /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 05 BAITIMORE WI If Under 1 Year | If Under 24 Hrs. | MORE OhN 6. Sex 8. Date of Birth (Month, Day, Yea July 2, 1928 7. Age (In yrs last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 425-36-9722 1 □ M 2 □ F 75 Yrs Mississippi Director Usual Residence of Decedent Manyland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Delaware Wilmington New Castle 1 ☐ Yes 2 No Director the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19808 Івтя 23в 3324 Heritage Drive Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced other than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer DuPont Company permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Kelly Johnson Vesta Aline Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy H. Johnson/Wife 3324 Heritage Drive Wilmington Delaware 19808 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Crematory 1/20/04 Wilmington Delaware 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland once tou husting 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Endocarditis 3 weeks resulting in death) /Medical Due to (or as a consequence of): Examiner 10 years Mitral valve replacement if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician P.O. Box 68760 Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 № No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔀 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 January 18, 2004 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC SCHMIDT MID THE JOHNS HOPKINS HOSPITAL GOD NORTH WOLFE STREET BALTIMORE MARYLAND 21287 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State

DHIVE 17 Hev 1/2001

Registrar

			- State Amend Item 19b	State of Maper FH,G827,	aryland / [,01/20/04d	Depa il ©e /	artmen <i>tificati</i>	t of H e of L	ealth a Death	and M	ental Hy	gien Reg. No	/Ullu	01068	
	Physici	an	1. Decedent's Name (First, Middle, Las	t)			1.000				2. Date of De Month	Da	ay Year	3. Time of Death	
l I	/Medic		GABRIELLA				JACOB		Landing	4 De ath	JANUE		/ 6 3.00		
	Examir	ier	4a. Facility Name (If not institution, give 8909 REISTERSTOWN	ROAD #21			BALT	IMOR	Location o			BA	ALTIMORE		
	Funeral Director			X	e (In yrs. last bii 81	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da JAN 5	1923	HUNG	thplace (State or Foreigr punity) ARY	
Pac	A ==		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation							10d. Inside City Limits	
2	P-1 sh	ţċ	MD BALTIMORE		BALTIM	10RE								1 □ Yes 2 No	
di At	They win it is nous are bean win the maryano Hygiene. Hygiene they hen "naturel", or Items 23a or 28a-1 show ant, the Medical Examinar must be notified at	eral Director	10e. Street and Number				10f. Zip					10g. C	itizen of What Co	ountry?	
4			8909 REISTERSTOWN ROAD #21 11. Marital Status 12. Was Decedent Ever in U.S. 13.					Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)					USA 14. Race - American Indian,		
036		by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			f Yes, spec		Specify:	, Puerto f	Rican, etc.)	5-	Black, Whit	te, etc.	
5-0	natur	Completed by	15. Decedent's Ed (Specify only highest grad		16a	(Give	ient's Usua kind of wai	rk done d	luring most	of working	ng	16b. h	Kind of Business	/Industry	
2121	be fred within 72 nd hal Hygiene ed other then "nature event, the Medical		Elementary/Secendary (0-12)	College (1-4or 5	5+) HO	life. I	AKER	se retired					HOME		
	d da d	To Be (17. Father's Name (First, Middle, Last) GERSHON	GRUNW				1	BERTH	ΙA	(First, Middle	(U)	NKNOWN)		
	5 5 5 5	•	19a. Informant's Name/Relationship (7 MRS.BARBARA WALLEN		IGHTER 1	651 in 265	g Address Z GRE	(Street a	nd Numbe RING	r or Rura. AVE	OWINGS	er, City MIL	or Town, State, I	Zip Code) 21117	
o -	0		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place o	f Dispo	sition (Nan matory or o	ne of ther place	e) 1		2004	^{20c.} L	ocation - City or INGDALE	Town, State	
Baltin	Department Important: I Important: I any injury o		21. Sign of the Funeral Service Ucon		,								& BROS.		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do								LLLL 911D.	Approximate Interval Between	
E	rive law requires that the deant certificate be executed that the state of the attending physician and the page 2 should be detached for use as the burial-transit transit that the state of the state o	Completed by Physician/Medical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to finite classe. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									AGE.			
O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pr Other (sp						23d. Date of del Month	livery Day Year	
ds, P.O			Part II. Other significant conditions continuing to death but not resulting in the underlying cause given in Part I.												
of Vital Records,									performed / death?		utopsy findings available completion of cause of				
/ita	is certificate director, pag	Be C	25. Was case referred to medical examiner?							of Death	(Check only				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of						Home 5 ☐ Residence 6 ☐ Other (Special 28d. Describe how injury occurred			cify)		
		tion	27. Manner of Death 1. Matural 5. Pending 2. Accident investigation	(Month, Da	Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. M 1 □ Yes 2 □ No		Ed. Describe flow injury occurred								
Division		Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
- Intimodel		Medical Ce	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best iner: On the basis of and manner sta	f examination ar	e, death	occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	nd due to the ed at the time,	cause(s date an	and manner as d place, and due	s stated. to the cause(s)	
			29b. Signature and title of certifier						d. Date signed (Month, Day, Year)						
) [5		> illimited	XIII			H	450	131			Jai	nuary i	16,2004	
	18		30. Name and address of person who con Deborah I Pie	rce 70	leath (Item 23a)	(Туре.	Print)	itTS	AVE	NVE	1 B	ALT	MORE	16,2004 MD 2120	
	Sta Registi		31. Date filed (Month, Day, Year)	22. Registr	ar's Signature	for a									

	04-0133 AKG		Please Amend Item	Type or Print in B	lack Ind	elible Ink. 04 tas,	Ensure Al	Copies A	re Legible.	
2	FINO		1 - For Amend & Unpend 1 Registrar	Type or Print in B #2 per dyr G82 "State of Maryland Item #1,23a,27,28a	f per m	e G828 2/3 ficate of i	3704 tas Death	Reiliai mygi Rei	erie Z U U i	+ 01069
	Physicia		1. Decedent's Name (First, Middle, Last		n J	r.			1/5/2004 Day Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	1	b. City, Town, or	r Location of Death	Janaa	4c. County of Dea	
2			2328 Madison Avenu			Baltimo:		n Data at Blat	N	A
000	Funeral Director		5. Social Security Number 6. Security Number 1] Usual Residence of Decedent	7. Age (In yrs. In MM 2□F 52		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, AUG. 17,	(ear) 9. Bi	aryland
	anyland show		10a. State 10b. County	10c. City	, Town or Loca	tion	1			10d. Inside City Limits
	vith the Maryla or 28a-f shov	ector	Maryland Balti	more Du	vings	: [VI 1	S			1 Nes 2 No
	ath with ti	Funeral Director	10e. Street and Number 4503 Runn	ymeade	Rd.	10f. Zip Code 2//	17	10	g. Citizen of What C	1
36	within 72 hours after death with the Maryland phe Pone than "natural", or Itams 23a or 28a-1 show than "natural" to rediffer at	by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	If Y	as Decedent of H es, specify Cuba Yes 20 No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	72 hours "natural",	ted	15. Decedent's Edi . (Specify only highest grad	ucation	16a. Deceder	nt's Usual Occup	ation	na 1	6b. Kind of Business	s/Industry
121	be filed within 7 ital Hygiene. ed other then "n event, me Medi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use retired	during most of worki	V	110 IT	- and anot i
9	D 0 2	CO	17. Father's Name (First, Middle, Last)			auts	18. Mother's Name	(First, Middle, M	<u>ellow</u> II aiden Sumame)	an Sportation
lan	should be nd Mental marked c	To Be	Nathaniel	Johnson	Sr.		Lurl	ena -	Parhe	
Maryland	s 1 and 2 should t Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T.	ype, Print) Wite)	19b. Mailing	Address (Street	and Number or Rura	I Route Number,	City or Town, State,	Zip Code)
	a E E		20a. Method of Disposition	Johnson	250	VIDE	et Ave.	603N	Cc. Location - City or	121215
nor	ages int of h t: If ite		1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crema	tory or other place		2004	De. Location - City of	Town, State
Baltimore,	permit. Pages 1 Department of H important: If ite any injury or ot once.	1	*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	7 11 111	22.1	leni Fa	ss of Facility	_	Delle.	IVIA.
ä	permi Depa impo any ir		Joseph	L. BUSG	1 205	22 Wil	NOFTE AV	e Bar	& Home	1216
*			shock or heart failure. List only o	lications that caused the death one cause on each line.	n. Do not enter	the mode of dyin	ig, such as cardiac o	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical	Ŋ	Immediate Cause (Final disease or condition resulting in death)	a. Narcotic and E		ntoxicatio	on			Grisor and Boath
	Examiner			Due to (or as a consequ	ience of):					
	B = E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	erice of):					
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ionoo of):					
.60		ā		Due to (or as a consequ	derice or).					
687	leath certificate I attending physi	ledic		d						-
Вох	th cert tendin r use	an/M	230. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		ctopic pregnancy			23d. Date of de	
0.	The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	by Physician/Medic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5□C	other (specify)			Month	Day Year
0	that the dined by the detached	y Ph	Part II. Other significant conditions co	entributing to death but not resu	ulting in the und	erlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
Vital Records,	w requires been sign should be					· · · · · ·		1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
eco	e law requ has been je 2 shoul	ompieted						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E	(0 (7	Con						perform 1D Yes 2	ed? death?	
		o Be	25. Was case referred to medical examiner? 1 ★★ es 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ I	ED/Outestiest	3□ DOA Oth	26. Place of Death er:			7.1
of		-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun Work	4 Nursing no	ne 5 Residen 28d. Describe hov		ecity) At scene
Sior	Attending Ir death.	atio	1 Natural 5 Pending 2 Accident Investigation	175/04	oundiury 20 p	M 1 🗆	Yes 2. No	Unknown		
Division	i giệ c	Certification:	3 Suicide 6 X Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify) Found at home	me, farm, stree	t, factory, office		28f. Location (Stre City or Town, Saltimore,	et and Number of R State) 2328 Ma Md	dison Ave.
	Hospitel 24 hours (Funerel stely (illed	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	/sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death o tion and/or inve	ccurred at the tin stigation, in my o	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier) 00	0.4	29c. License	e number	29	d. Date signed (Mon	th, Day, Year)
			tatrial	din-toll	Sh is	0.C.	M.E.	Já	nuary 6,	2004
			30. Name and address of person who o	0.11.17	23a) (Type, Pr		- Ol t	D 71.		2 04 004
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	TIT Pen	n street,	RATTIMO	re, Maryl	and STSOT
	Registr		JAN 2 0 20	04 1	E.	100				

DHMH 17 Rev 1/2001

Nathaniel Johnson Jr.

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 0 1070 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY Year Norbert 2004 Paul King, /Medical Jr. 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Yrs. Director 183-28-7301 68 1935 PAUsual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location worde | 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items 23a or 28a-f ehow ury or other traumatic event, II a Medical Examities to the fruitified at Director 1 ☐ Yes 2X No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13942 Jarrettsville Pike Funeral 21131 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No tryes, Give Year or Dates: 158-166 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Engineer Defense Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norbert P. King, Sr. Gertrude Marie Newmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is eny injury or other trau Katherine Jean King/wife 13942 Jarrettsville Pike, Phoenix, MD 21131 Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/21/04 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 21. Signature of Funeral S Michael J. Flatie

Lemmon Funeal Home of Dulaney Valley, Inc.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEVERE CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending use a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. ☐ Yes 2 ☐ No. the 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. RENAL FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen PERIPHERAL VASCULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No has autopsy performed? Yes 20 No certificate Division of Vital 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Tot Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 EP/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide I in by t 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) title of certifier 29b. Signature/a 29c. License number 29d. Date signed (Month, Day, Year) D 0053593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHRAF MOSTAFA 7505 ØSLER DRIVE SUITE 200 TOWSON MORYLAND 21204 14. 31. Date filed (Month, Day, Year) JAN 2 U 2004 32. Registrar's Signature State

DHMH 17 Hev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer John Edward Knapp **Physician** MANAYE 16 2004 /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day Year) Sept 27, 1915 Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral X**X M 2 □ F 88 212-07-2675 Maryland Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show hat be notified at MYes 2 No Baltimore Maryland N/ADirect 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA #1009 21211 3838 Roland Avenue death 1 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner of Black, White, etc. filed within 72 hours after 1xx Yes 2 □ No If Yes, Give Year or Dates:1941-45 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 200No Specity: Specify: δ white 3 X XVidowed 4 ☐ Divorced "natural" Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Baltimore Asphalt permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other that eny injury or other treumatic event, the 9008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth May Sheets John H. Knapp 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8628 Spruce Run Court Ellicott City, MD 21043 Phyllis Spence (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition ₩Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 1/21/2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 Funeral Selvice Ligensee 21. Signata Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tamponale ardiac mimete Physician /Medical Due to (or as a consequence of): Examiner ocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 □Unknown ardiomy opath 1 ☐ Yes 2 ☑ No Be Completed inducible nminalar 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 3€ NO 2 🗖 No 1 TYes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Cardiolosy 30. Name and address of perion of completed cause of death (Item 23a) (Tyrie, Print) Z44 W. Bolvedere 32. Registrar's Signature State 1030 B Registrar

184-20-9048	Tylew Lane 12. Was Decedent Eve Armed Forces? 12. Was Give Year or Dates: 12. Itation C 7. Age (I	77 Yrs. 77 Oc. City, Town or Lo Laurel ar in U.S. 13.1 1944 - 1946 16a. Decer (Give life.	Burtons If Under 1 Year Months Days acation 10f. Zip Code	If Under 24 Hrs. Hours Min. 7723 Ispanic Origin? (Specify:	8. Date of Birth (Month, Day, May 21,	Day	th Mery Itholace (State or Foreign ountry) Insylvania 10d. Inside City Limits 1 Yes 2 No ountry? erican Indian, te, etc.
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Holy Cross Rehabi i. Social Security Number 184-20-9048 Jsual Residence of Decedent 10a. State 10b. County MD Howard 10e. Street and Number 10709 East Crest 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Charles Krawchuk 19a. Informant's Name/Relationship (Ty Madeline Krawchuk/	TVIEW Lane 12. Was Decedent Ever Armed Forces? 12. Was Super Sup	77 Yrs. 77 Oc. City, Town or Lo Laurel ar in U.S. 13.1 1944 - 1946 16a. Decer (Give life.	Burtons If Under 1 Year Months Days cation 10f. Zip Code 20 Was Decedent of H If Yes, specify Cuba 1 Yes 22 No	SVIIIe If Under 24 Hrs. Hours Min. 0723 Spanic Origin? (Sr. Specify:	8. Date of Birth (Month, Day, May 21,	Montgor Year) 9. Bir 1926 Per g. Citizen of What C USA 14. Race - Am Black, Whi	thplace (State or Foreign ountry) nnsylvania 10d. Inside City Limits 1 □ Yes 2 ☑ No ountry? erican Indian, te, etc.
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184-20-9048 Jaual Residence of Decedent IOa. State	12. Was Decedent Ever Armed Forces? 12. Was Decedent Ever Armed Forces? 12. Was 2 One If Yes, Give Year or Dates: Ucation (a completed) College (1-4or 5+)	Oc. City, Town or Lo Laurel ar in U.S. 13. 13. 1944 - 16a. Decece (Give life.)	10f. Zip Code 2 (Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No dent's Usual Occup kind of work done	ispanic Origin? (Sp in, Mexican, Puerto Specify: ation	pecify Yes or No- p Rican, etc.)	g. Citizen of What C USA 14. Race - Am Black, Whi	10d. Inside City Limits 1 ☐ Yes 2 ☑ No ountry? erican Indian, te, etc.
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12th 17. Father's Name (First, Middle, Last) Charles Krawchuk 19a. Informant's Name/Relationship (Ty Madeline Krawchuk/		Ma		i)	King		
Charles Krawchuk 19a Informant's Name/Relationship (Ty Madeline Krawchuk/			rketing P	Manager		Insuranc	ce
19a. Informant's Name/Relationship <i>(Ty</i> Madeline Krawchuk/			5	18. Mother's Nam	ne (First, Middle, M.	laiden Sumame)	
Madeline Krawchuk/				Anna Kr	ietz		
	ype, Print)	19b. Mailin	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
20a. Method of Disposition	/Wife	10709	East Cre	estview I	ane, Lau	rel, MD 20	723
300		20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	(8)	Date 2	0c. Location - City or	Town, State
		-			//2004	Fulton, MI	
21. Signature of Funeral Service Licens						Funeral Ho	ome, P.A.
Lewel on	Char M.	100160 3	13 Talbo	tt Avenue	, Laurel	, MD 2070	7
23a. Part 1. Enter the disease, or compl	lications that caused th	e death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Immediate Cause (Final							Onset and Death 1 Week
resulting in death)	a						1 week
	·		Dementia				5 Years
Sequentially list conditions, if any, leading to immediate	D		DOMORIOLA				
Cause. Enter Underlying Cause (Disease or injury that initiated events							
resulting in death) Last	Due to (or as a	consequence of):					
	d						
23b. Was decedent pregnant			Tectonic pregnancy	,			,
in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin					Month	Day Year
9 🗍 Unknown	3 D O IK IOWII						
Part II. Other significent conditions co	entributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	1		
					1 ☐ Yes	s 2 23.No 3 □ P	robably 4 Unknown
							utopsy findings available completion of cause of
					perform	ed? death?	
25. Was case referred to medical				26. Place of Dea			7171
examiner? 1 ☐ Yes 2∑ No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	er: 4 💢 Nursing H	ome 5 Resider	nce 6 Other (Spe	ecify)
27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	y at	28d. Describe hov	w injury occurred	
2 ☐ Accident investigation		out, many					
determined	286. Place of injury	- At home, farm, sti	reet, factory, office				lural Route Number,
	Sanding, Sto.	·//			,		
one)					-		74 4 4
29b. Signature and title of certifier	MD					d. Date signed (Mon	th, Day, Year)
Mathan			1) (シン のも 1	,	January 1	16, 2004
The second secon		th (Item 23a) (Type,	Print)				
Aruna Nathan,	11125 Rocky	ille Pike	e, Suite	208, Rock	ville, M	D 20852	
31. Date filed (Month, Day, Year)	32. Registrar	S Signature					
	Carry Cary	Care Comment Care **Complete Complete C	Commetery, crematory or other place Commetery Co	Commerce Commerce	St. Paul's Cemetery 1/17/2004	## Sparial Comments of Comment	

			For State C	of Maryland / [Department of Certificate of		•	giene 2 (004	01073
	Physici	an	Decedent's Name (First, Middle, Last) Rose Ellen Kolbe	, <u>a si di an al-</u>	-		2. Date of De	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and no		4b. City, Town,	or Location of Death	Manne	4c. County	of Deeth	4.125
	Funeral Director		5. Social Security Number 6. Sex 213–20–7948	7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da NOV 5,	th ly, Year) 1924	1/a 9. Birthple Counti Mary	
	death with the Maryland rms 23s or 28s-1 show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town					10	d. Inside City Limits
	or 28a	Director	10e. Street and Number	Daren	10f. Zip Code			10g. Citizen of V	What Count	iy?
336		by Funeral	660 Queensgate Road 11. Marital Status 1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Year or I	2X No	13. Was Decedent of If Yes, specify Cut		ecify Yes or No Rican, etc.)	United 14. Rac Black Specify	e - America k, White, e	n Indian,
Baltimore, Maryland 21215-0036	filed within 72 hours after Hygiene. Wher then "natural", or Ite ont, Tre Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Bu		Cemeterv
land	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Gustavus Kolbe			18. Mother's Name				cellecery
Mary	d 2 sho th and h 7 Is ma trauma		19a. Informant's Name/Relationship (Type, Print) Stephen Kolbe / Nephew		. Mailing Address (Stree					
nore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes.		Stephen Kolbe / Nephew 20a. Method of Disposition 1 Stephen 2 Cremation 3 Removal from 4 Domation 5 Other (Specify)	20b. Place of cemeter	50 Queensga: Disposition (Name of by, crematory or other place) Nawn Cemeter	ace)	Date	20c. Location -	City or Tow	m, State
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee	ulain	22. Name and Addr		ibbard F	Baltimo:	Home,	Inc.
	Physician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	PNEUR	not enter the mode of dy	ing, such as cardiac o			1	Approximate niterval Between Onset and Death
MM	Examiner	ner	Sequentially for conflicts	(or as a consequence of	of):	MILM			5	ZPA
8760,	ate be executed physician and the burial-transit	dical Examiner	triat initiated events	(or as a consequence of	VASCUL	AR A	ccib	ENT	2	> ~ ~~ T
.O. Box 68	e death certific the attending pad for use as	Physician/Med	in the past 12 months?	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey		23d. Dat Mor	e of delivery	r Day Year
rds, P	quires that the signed by to the detact	by	Part II. Other significant conditions contributing to d	eath but not resulting in	the underlying cause gr	ven in Part I.		obacco use contr es 2 No		cause of death?
S S Se		Completed					24a. Was autop perfor	rmed? d	Vere autops rior to comp eath?	sy findings available of cause of
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital:	npatient 2 ER/Out	tpatient 3☐ DOA Ot	26. Place of Death her: 4 \(\sum \) Nursing Hor			y (Specify)	_
1 be vision of	Jing After fune	atlon: T	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	of Injury 28b. T	ime of 28c. Inju njury Wo			ow injury occurre		
Divis	i Sir e	Certification:	4 Homicide build	ing, etc. (Specify)	rm, street, factory, office		City or Tow			
\leq	Hog Furth	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base one one of the base one one of the base o	best of my knowledge asis of examination and ner stated.	, death occurred at the ti d/or investigation, in my (ime, date and place, a opinion, death occurre	and due to the d ed at the time, d	cause(s) and mar date and place, a	ner as stat nd due to th	ed. ne cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	AL RESID	29c. Licens	se number	_	29d. Date signed		ay, Year)
	II)		30. Name and address of person who completed cau		Type, Print)	10+00		ANUAY		+, 227 4=
150	N Sta	te	31. Date filed (Month, Day, Year) 32. F	egistrar's Signature	900 CAR	TON AVE	NWE P	BALTIN	WRE	DSSSCOW
	Registr	-	JAN 2 0 2004	Salva Jo						

			1 - For State Registrar		aryland / Dep	artment of Hea rtificate of De	ith and Me	ental Hygie	ene	4 0107
	Physicia	an	1. Decedent's Name (First, Middle, Las		_			2. Date of Death Month	Day Yea	3. Time of Death
	/Medic				J. Konert			January	15 200	4 3:35 A. M
ا	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Loca			4c. County of D	
			1916 Peveril Co		(In yrs. last birthday)	Huntingt		9. Data of Righ	Calve	
Di	uneral rector			CM ONE	70 Yrs.		ours Min.	8. Date of Birth (Month, Day,) Sept. 24	(ear) 1, 1933	Birthplace (State or Foreign Country) Maryland
d Z I Z 13-0050 filed within 72 hours after death with the Maryland Hygiene.	MON.		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mar	fs 1-0	tor	Maryland		Baltim	ore				1 ☐ Yes 2 🖪 No
th th	or 28	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What	
ath w	23a	ra l	4216 Doris Ave	nue	-	2122			U.S.A	•
er de	items Dar 0	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spec exican, Puerto R	rify Yes or No- lican, etc.)	14. Race - A	merican Indian, hite, etc.
rs aft	r, or	by F	1 ☐ Never Married 2 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 20X N If Yes, Give Year or Dates:	10	1 ☐ Yes 21② No Sp	pecify:		Specify:	White
2 Pg 2	etura cal E	Ped	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupation		16	b. Kind of Busine	ss/Industry
Mally fall of 1215-0050 nd 2 should be filed within 72 hours aft lth and Mental Hygiene.	Medi	pie	(Specify only highest gra	de completed) College (1-4or 5-	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	g		•
ad with	a a	Completed	9th		Subs	stitute Teac	cher		Schoo!	L
ag Es Eg E	d oth	Be (17. Father's Name (First, Middle, Last)		2	18.		(First, Middle, Ma	iden Sumame)	
bluo	etic e	၉		Milhollan			Marie			
12 sh h and	7 is m		19a. Informant's Name/Relationship (7	•		ng Address (Street and N				
1 and Healtl	ther 1		Ellen Muth / Day 20a. Method of Disposition	ugneer	A STATE OF THE PARTY OF THE PAR	Cox Landing sition (Name of place)	Court		c. Location - City	yland 21226
partificação, permit. Pages 1 ar Department of Hea	1 or o		1X Burial 2 ☐ Cremation 3 ☐							
iit. P.	Importent: If item 27 is marked other then "netural", or items 23a or 28e-f show eny injury or other treumetic event, the Medical Examinar must be notified at ones.	i	*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen							le, Maryland
Depart	eny ii	ļ	freeme m		ule 1	OO1 Ditabio	"George	J. Gone	ce Funer	al Home, P.A. ryland 21225
			23a Part1. Enter the disease, or comp shock, or heart failure. List only		7,-					Approximate
Cities.	sician		Immediate Cause (Final							Interval Between Onset and Death
	edical		disease or condition resulting in death)	u	tatic Colo	n Cancer				1 month
Exa	miner									
7	_	ner	Sequentially list conditions, if any, leading to immediate cause. Entert Inderlying	b. Due to (or as a	consequence of):					
te be executed	nd trans	Examiner	that initiated events	c.						
te be exe	cian a	Ä	resulting in death) Last	Due to (or as a	consequence of):					
cate	physician and as the burial-transit	dicai		d						
The law requires that the death certifical	signed by the attending ph d be detached for use as th	by Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy				100	
nat the death cert	for u	ian	in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
) e	y the	ysic	1 ☐ Yes 2 XNo 9 ☐ Unknown	9☐ Unknown	anie or death 3 c	Cities (specify)				
that	deta	P V	Part II. Other significant conditions or	ontributing to death bu	t not resulting in the u	nderlying cause given in I	Part I.	23e. Did tobac	co use contribute	to the cause of death?
The law requires t	n sigr							1 🗆 Yes	2 <u></u> № 3 🗆 I	Probably 4 Dunknown
₩ rec	s been si should	Completed						24a. Was an	24b. Were	autopsy findings available
he la	age 2	E O						autopsy	prior to death?	completion of cause of
Ë	certificate ha	BeC	25. Was case referred to medical			26.1	Place of Death (1 Yes 25 Check only one)	No 1 1 Ye	s 2 No
Attending Physicien: r death.	. <u>∞</u> ¬	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatien	nt 2 ER/Outpatien				e 6 ⊠Other (Sp	ecifySon's home
l or Attending Physicien: 1 after death.			27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of			d. Describe how) Tomo
endir sath.	tor: Aff the fur	atic	2 ☐ Accident investigation			M 1 ☐ Yes	2 🗆 No			
r Att	Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuit building, etc.	ry - At home, farm, str. (Specify)	eet, factory, office	28	f. Location (Stree City or Town, S		Rural Route Number,
oitel o	led is						1			
Hospitel or 24 hours afte	To the Funerel Direc completely filled in by	edical	29a. Certifier 1 ★ Certifying Phy (Check only 2 ★ Medicel Exem	ysicien: To the best of	f my knowledge, death examination and/or inv	occurred at the time, da restigation, in my opinion	ite and place, an i, death occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)
To the within 2	To the	Med	29b. Signature and title of certifier	and manner stat	eu.	29c. License num			Date signed (Mor	
¥ ×	F 8		1			D 5602		236.		16, 2004
10			30. Name and address of person who g	ampleted cause of de	ath (Item 23a) /Type	Print)				
W			Dr. Kenneth Abb			·	110	Prince F	rodori d	, MD. 20678
	Stat	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Road Suite	7 110	- LIUCE I	redelick	4 MM. ZUD/8
	Registra	ar	JAN 2-0 2	2004	Marie 1	17				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year January 17, 2004 **Physician** 5:55p /Medical 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lorien Nursing Home Mt. Airy Carrol1 If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√F Months Hours 188-01-1429 Yrs Director Sept 14 1916 PA Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Md 1 ☐ Yes 2 No Director Howard Glene1g 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14900 Triadelphia Mill Road 21738 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 □ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store 12 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Lee Clara Foss ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. William Aylesworth (Cousin) 14900 Triadelphia Mill Rd., Glenelg, MD 21738 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dunmore Cemetery 1/23/04 Scranton, PA 21. Signature of Funeral Service Licensee FAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Altero Sclevotic Cardiovancular Dipease Immediate Cause (Final disease or condition resulting in death) Weatca Examiner Due to (or as a consequence of):
D(Ghetes Mellitus Medical Certification: To Be Completed by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificete be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the ettending physician and burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manger of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation Natural 2 No 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the ‡ 29b. Signature and title of certifier 30641 Back River Well Road Balhime 2/221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Sahanalm' 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 2 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Sophie V. Lambo January 260 Y 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kosedale Franklin pita Kaltimore 1are If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) April 29, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2€ F 71 Director 199-24-4034 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "neturel", or items 23e or 28e-f show treumatic event, the Madical Exercit at mast ke modified at Middle River **Funeral Director** MD Baltimore 1 ☐ Yes 🕏 💀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Hammock Trail 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No SpecifWhite Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker ownhome 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; If Item 27 Is marked oth any jury or other treumatic event 2008. Be Mary Briski George Verbus ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Lambo/husband 5 Hammock Trail Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 1/20/04 Baltimore MD HollyHillCemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service License Baltimore MD 21221 300 Mace Ave. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Phermonia **Physician** day /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical anding use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by been signe should be 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ENOCOL CINOMO performed? certificate 2 X.No 2 ☐ No 1 🗌 Yes 1X Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1. Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М death. 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Somare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harvinder 31. Date filed (Month, Day, Year) Arora, 700 32. Registr

			Please 1				. Ensure All	•	•	
			For State	State of Ma		artment of terrificate of	lealth and Me		2004	01077
			Registrar 1. Decedent's Name (First, Middle, Lass	")		Timeate or		Reg. No 2. Date of Death).	3. Time of Death
	Physici	an	0	c 1	= m m =	\wedge		Month Da	y Year	MILLAM
	/Medio		4a. Facility Name (If not institution, give	street and number)	271.11.10	4b. City, Town, o	or Location of Death	100000 1	. County of Death	111:73
	Examir	ıer	1100x R 7 H 51 00 51		0	Bes A	C.Q	V	ARFOR	
I	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Year)		place (State or Foreign
	Director		220 20 8119 11	DM 250F	S Yrs.	Months Days	Hours Min.	81 4792	AM EL	
	р ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	conting				10d. Inside City Limits
	Maryland -f show lind ut	_) o				1 ☐ Yes 2 Mills
7	he M	Director	10e. Street and Number	5RQ	1927 6	10f. Zip Code		10a Ci	tizen of What Cou	
7	death with the ms 23a or 28a	급		~ ~ ~ ~			.\.	109.0	1 0 0	intry :
-	leath	Funeral	301 Loto (U) L	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (Speci an, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ameri	ican Indian,
X.	rs after d	Ξ	1 ☐ Never Married 252 Married	1 ☐ Yes 2 ☑ 1				can, etc.)	Black, White	, etc.
37	n 72 hours after death with the Marylar "naturel", or Hems 23a or 28a-f show adical Examinar must be molified at	P	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	HITE
W3	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deci	edent's Usual Occup	pation during most of working	16b. K	ind of Business/Ir	ndustry
2, 72	within ene then "	npie	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	(d)		A \1	
74.2	filed w Hygier Ither th	S	13785.		HO	WILLY	5_/2			ME_
3 6	be fill	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (rirst, Middle, Maider	Sumame)	
Z 2	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma	2	SOMARO C	OUASITO	VEC 100 M	: Add /C	rilliac	1 264	E RIGUE	-0-11
maryland	s 1 and 2 should be filed within f Health and Mental Hygiene item 27 is marked other then other traumatic event, Ite Ms		19a. Informant's Name/Relationship (7	ype, Printi	190. Mail	ing Address (Street	and Number or Rural I	House Number, City	or rown, State, 21	p Code) 21014
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42 Baltimore,	permit. Pages Department of t Importent: if ite any injury or of		*4 □ Donation 5 □ Other (Specific	\	PHON IC	2. Name and Addre	ass of English	4 1001	7000	J. H. SIED
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~ =			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	fications that caused	the death. Do not er	S (12,000+c	ng, such as cardiac or	respiratory arrest.	High I sel	Approximate
			shock, or heart failure. List only of	ne cause on each li	ne.	1.	#	•		Interval Between Onset and Death
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. 687	death certificate e attending physi id for use as the b	Physician/Medic	IF FEMALE:					1		
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O.	0 4 2	sici	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at 9□ Unknown	t time of death 5	Other (specify) _				
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4 8	v requires tha been signed should be de	þ	7 att ii. Stiller digitilleath somattens of	, milesting to double s	at that to be a first to be a	andonymy dadoo gr			_	bably 4 Dunknown
S S	v requir been s should	Completed								
360	e tav has	ig i						24a. Was an autopsy performed?	prior to co death?	opsy findings available empletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	pag at							1 ☐ Yes 2 ☑ No		2 □ No
Vital Θ	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otto	26. Place of Death (
of	pitel or Attending Physicien: ours after death. leral Director: After this certific filled in by the funeral director,	5	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 ER/Outpatie	IN SUIDON	4 Nursing Home	e 5 Residence		(y)
o	Attending Fr death. ector: After by the funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injury		rk?]Yes 2 □ No			
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1	Hospitel 24 hours a Funeral I		29a. Certifier 1 Certifying Phy	ysician: To the best	of my knowledge, dea	th occurred at the t	me, date and place, an	d due to the cause(s) and manner as s	stated.
$\frac{1}{177} \frac{1}{12} $	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Examone)	and manner st	ated.	nvestigation, in my	opinion, death occurred	at the time, date an	a piace, and due t	to the cause(s)
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	10		30. Name and address of person who of Joseph ANO	completed cause of a	leath (Item 23a) (Type	, Print) 02 S. /	Hwood R	d. BELI	AIR, M	1) 2/014
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		1 - For Amend Item Registrar 1. Decedent's Name (First, Middle,			Tillicate Of L	704.77	2. Date of Death	No. U U 4	3. Time of Death
Physic	an	Roy E. Llew					Month	Day Year	
/Medi		4a. Fecility Name (# not institution,			4b. City. Town, or	Location of Death	01	4c. County of De	
Examir	iei	Sacred Hea		7	Λ .	erland		ALLEC	
uneral			Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo		mplece State or Forei
Director		220-28-9623	1X M 2□F 74 -€	5 Yrs.	Months Days	Hours Min.	Dec 17,	1929 Ma	aryland
2 2		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Le	cation				10d Inside Ob. Lini
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic evant, the Marical Exercitive must be notified at once.	7	MD Allegar		Lonacon					10d. Inside City Limit
28a-f	Completed by Funeral Director	10e. Street and Number					10-	Cities of Miles C	
a or	ក់	57 Jackson Stree	o.†		10f. Zip Code	21539	log	Citizen of What C	ountry?
ns 23	era	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of Hi		ecify Yes or No-	14. Race - Am	erican Indian
The The	Fun	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Z No		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	nite
satur	ted	15. Decedent's	Education		dent's Usual Occupa		16	o. Kind of Business	s/Industry
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d oth	Be	17. Father's Name (First, Middle, La Marcellus Kusse - <u>Marcellos Russe</u>	11 Llewellyn			18. Mother's Name	(First, Middle, Mai	den Sumame)	
arke	2	-Marcollos-Russe	11 Llewellyn	_		Anna Gard	lner Cutt	er	
e m		19a. Informant's Name/Relationship			ng Address (Street a		· ·	ity or Town, State,	Zip Code)
em 27 ther tr		Betty Llewellyn			Box 201 M				
H ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Ob. Place of Dispo cemetery, crea	osition <i>(Name of</i> matory or other place	9)	ate 200	. Location - City or	r Town, State
jury		* 4 X Donation 5 □ Other (Spe	cify)	4.14					
Importent: I any injury o once.		21. Signature of Euner Service Lice Ronald S	655 W. B	-1	a .				
- = a		/ Silcery	1 1 dall	I DC	TTTIMOTE,	$\mu \nu = 21201$			Street
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the ly one cause on each line.	death. Do not en	ter the mode of dying	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
ician		Immediate Cause (Final disease or condition	Respira	tory ta	dure				Onset and Death
dical		resulting in death)	Due to (or as a co	nsequence of):		/			10
	_	Sequentially list conditions,	b. Chronic	OUST	active po	almonary	dista	10	10 years
sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence of):					
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physic the	d	· · · · · · · · · · · · · · · · · · ·	d						
attending physical for use as the b	Completed by Physiclan/Medl	IF FEMALE:	23c. If yes, outcome of p	regnancy				001.0	
atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
ched	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	o death 31	J Otter (specify)				
be detached f	4	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
sign Id be	d b	Osteumyelitis	, non-insu	lin deve	adent die	abetes	1 ⊠ Yes	2 □ No 3 □ P	robabiy 4 🗀 Unknov
s peen si should I	lete		1 fibrillution				24a. Was an	24h Mara a	utopou findinos puedeb
iis certificate has director, page 2	d E						autopsy performed	prior to	utopsy findings availab completion of cause of
ficate			rial peripher	al VUSCU.	la disease	4	1 ☐ Yes 2 🖺		s 2□No
recto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	a∏50/0 · · ·	othe	26. Place of Death	The second secon		
r this ral da	- T	27. Manner of Death	28a. Date of Injury	2 ER/Outpatier	IL 3L DOA	4 🗆 Nursing Hor	ne 5 🗌 Residence 28d. Describe how i		ecify)
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y the	flca	3 ☐ Suicide 6 ☐ Could not	be as Place of Injury	At home, farm, str			8f. Location (Stree	t and Number or R	ural Route Number,
Unector:	Certification;	4 Homicide	building, etc. (S	pecify)	,,,		City or Town, S	tate)	
file		29a. Certifier 12 Certifying	Physician: To the best of m	y knowledge, deat	h occurred at the tim	e, date and place, a	and due to the caus	a(s) and manner a	s stated
	Medical	(Check only 2 Medical Ex	aminer: On the basis of exa and manner stated.	imination and/or in	vestigation, in my op	inion, death occurre	d at the time, date	and place, and du	e to the cause(s)
e Fun letely	9	29b. Signature and title of certifier	(1)		29c. License	number	29d.	Date signed (Mon	th, Day, Year)
sompletely	2		111	2 .	Do:	100-		· in -	2011
To the Funerel Director: After th completely filled in by the funeral	2	1/6	Allow Cir	MA	1021	482	i /	an H. Z	004
To the Fun completely	2	30. Name and address of person wi	o completed cause of death	(Item 23a) (Type	D21	985		an A, Z	004
To the Funerel completely filled	~	30. Name and address of person of Thomas J. Do	O completed cause of death	(Item 23a) (Type.		Lona	coning.	md 21.	559

			State of Maryland / Department of Health and Me 1- State Registrar Certificate of Death		giene	2006	01070
	Physici /Medi		1. Decedent's Name (First, Middle, Last) CATHERINE HARVIN LEMON J	Month Month		2 ^{Year} 4	3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death S I now Hospital of Boutinere 5. Social Security Number 6. Sex 7. Age (In yrs, Jast birthday) 1 Under 1 Year If Under 24 Hrs 8.	. Date of Birth			Alace (State or Foreign try)
	Director wowa-		248-52-4304 1LIM 224 Yrs. White State Variable V	FEB. 2	7,19	31 Sout	Od. Inside City Limits
emon	with the Mar e or 28a-1 st Lbs notified	Director	MARYLAND N/A SALTIMORE 106. Stylest and Number 10f. Zip Code	: C1	77/ 10g. ¢itizer	n of What Coun	1 X Yes 2 □ No try?
rine l	death	by Funeral Directo	3904 WooD HAVEN AVENUE 2/2/16 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Sive	fy Yes or No- can, etc.)		Race - America Black, White, o	
Cotherine	s within 72 hours after liene. r than "netural", or Ite	Completed b	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			of Business/Ind	,
0.5 yland 21	000	To Be Co	3RPGRADE HOMEMAKER 17. Father's Name (First, Middle, Last) TAMES PLOWDEN OREE	First, Middle,		mame) HIN	es Es
hent known as	Pages 1 and 2 should bent of Health and Mer nt: If item 27 is mark iry or other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural File Control of Date (Street and Number or Rural File Control of Date (Street and Number or Rural File Control of Date (Street and Number or Rural File Control of Date (Street and Number or Rural File Date (Street and Number or Rural Fil	AVENC	IE, B		40.21216
Pahent	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address, of Facility BRG 21. Fig. 70.	AVE.	BA	FUNERA LTO. MI	11 HOME 0. 21217
8750	Physician /Medical Examiner paper paper per per per per per per per per per	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	espiratory afr	est,		Approximate Interval Between Onset and Death
P O Box 68	ath certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d	Date of deliver	y Day Year
Property P	wrequires that the de been signed by the s should be detached to		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Meningosis carried and the significant conditions contributing to death but not resulting in the underlying cause given in Part I.				e cause of death?
Division of Vital Records	sicien: The law requirections to age 2 should rector, page 2 should rector.	e Completed by	DM 25. Was case referred to medical 26. Place of Death C	24a. Was a autops perform	med? 2 12 No	prior to com death?	sy findings available apletion of cause of
of V.	ding Physicien: h. After this certific	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 27. Marrier of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?		ence 6)
Division	itel or Attendir irs after death. ral Director: Al	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	n, State)		Route Number,
0	To the Hospitel or Atte within 24 hours after de To the Funeral Directo com, letely tilled in by th	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	at the time, da	ate and pla	d manner as sta ice, and due to igned (Month, D	the cause(s)
	F 3 F 8		30, Name and address of person who completed cause of death (Item 23a) (Type, Print) INS Brown MD IN Earth			ary 15	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	nere			
	riegisti	al	JAN 2 0 2004 Separate 15 paparate				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dev **Physician** MATTHEW JOHN LAMARTINA sanuare 18 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Fecility Name (If not institution, give street and number) Examiner ANNE ARUNDEL SLEN BURNIE HOSPITAL NORTH ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | JULY 15, 1960 | MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1⊠M 2□ F Director 217-90-6908 43 Usuel Residence of Decedent MATTHEW 1 and 2 should be filed within 72 hours after death with the Maryland Haalth and Mental Hygiene. em 27 la marked other than "natural", or items 23a or 28e-f show ther traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County Directo GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? UNITED STATES 7765 FREETOWN ROAD 21.061 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: WHITE altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DISABLED N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GRACETTA DEBUON JOSEPH J. LAMARTINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 tment of Haalth a JOSEPH J. LAMARTIN - FATHER 1035 W. NURSERY ROAD LINTHICUM, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JAN DARY 1 ☑ Bural 2 ☐ Cremation 3 ☐ Removal from State ò 22, 2004 GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PK. © Other (Specify) 4 | Donation of Funeral Service KIRKLEY RUDDICK TUNERAL HOME P.A. 421 CRAIN HIGHWAY S.E GLEN BURNIE MARYLAND 23a. Part1. Enter the cheese, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA Examiner Due to (or as e consequence of) Examine SEPSIS Hospital or Attending Physician: The law requiras that the death certificate be executed bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) 部 Due to (or as e consequence of):

Records, P.O. Box 68760 Division of Vital

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I Director: A

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29a. Certifier

(Check only

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29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

JAN 2 0 2004

death.

hours after within 24 hours a

To the Funeral I.

completely filled filled

To the

by Physician/Medical Part II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed ON NO 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Inpatient 2□ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Natural 1 TYes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

+111

1005597

WAY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

2004

Black, White, etc.

29d. Date signed (Month, Day, Year)

18,

MD

2004

20904

TANVARY

Spring

SILVET

10:45 AM

9. Birthplace (State or Foreign

21090

21061

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2 No

State Registrar

32. Registrar's Signature

leassa hun

11500

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Desse

DHMH 16 Rev 6/95

MD

Sutherland

an e	et Lee		For State Registrar	State of M	aryland		artment of Heal rtificate of Dea			gien: Reg. No	2 U U	-	0108		
	Dhuoisi		1. Decedent's Name (First, Middle,	Last)					2. Date of De. Month	ath Da	ay Yea		3. Time of Death		
	Physici /Medio		Janet	Lee			,		January	y 15	2004		800 a м		
1	Examir	er	4a. Facility Name (If not institution,				4b. City, Town, or Loca			40	County of De		~		
-			9410 Owings Hei					s MIlls			Balt				
	Funeral Director		217-70-0780 Usual Residence of Decedent	5. Sex 7. Ag	je (In yrs. las 49			ours Min.	8. Date of Bird (Month, Da MAY 5,	y, Year 195		country ryla	ce (State or Foreign i) and		
	land land		10a. State 10b. County		10c. City,	Town or Lo	ecation					10d	. Inside City Limits		
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	th the or 284	irec	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zip Code			10g. Ci	tizen of What (Country	17		
	23a c	aiD	9410 Owings He	ights Circl	e #102	2	21117			USA	1				
9	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, it a Medical Exentral results to notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces? d 1 Yes 2 1)	Was Decedent of Hispani If Yes, specify Cuban, Me 1 □ Yes 2 t No <i>Sp</i> e	ic Origin? (Spe exican, Puerto I ecify:	cify Yes or No Rican, etc.)	-	14. Race - An Black, Wh	nite, etc			
Ö	hours ural',	d b	3 Widowed 4 Divorced	Year or Dates:							Specify:	Bla			
Maryland 21215-0036	n 72 "nat	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of workir	ng	16b. K	(ind of Busines	s/Indus	stry		
12	withi lene. than	шс	Elementary/Secondary (0-12)	College (1-4or			Worked			N/A					
0	Hyg other	Be C	17. Father's Name (First, Middle, L	ast)		ICVCI		Mother's Name	(First, Middle,						
a	lid be lental rked o	To B	John Lee				Li	illian	Garriso	nn					
ary	2 should and Men is marke sumatic		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street and N				or Town, State,	Zip Co	ode)		
	and 2 ealth a n 27 is		Wendy Young/Car	etaker		5 B	Gwynns Mill	l Court	Owir	nes	Mills,	MD	21117		
Ore	of He of He f Item r oth		20a. Method of Disposition	Pomoval from State	20b. Plac	e of Dispo	sition (Name of natory or other place)	D	ate	20c. L	ocation - City o	r Town	State		
Ĕ	Pages ment of I ant: If Its ury or o		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.	ecity)	Meta		ematory Inc.			Ba1	timore,	MD)		
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funeral Service L Thomas Gr	ociety ck Road	of MD.	Inc	re, MD		228						
	ta Tana				the death.				respiratory ar	rest,	re, MD	Ap	ZZO oproximate terval Between		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a												
蒙	/Medical Examiner		Due / (or as a consequence of):												
		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Clisease of injury that initiated events	b. Due to (or as	a conseque	nce of):		-							
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	oce of):									
68760,	be eg			200 10 (01 23	u 001130qua1	100 01).									
289	tificate ng phys as the	edical		d								+			
O. Box	death cer e attendir nd for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 ∰Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Da	y Year		
2 .	that ned by deta	y Ph	Part II. Other significant condition	s contributing to death b	ut not resulti	ng in the ur	nderlying cause given in P	Part I.	23e. Did to	bacco (use contribute I	to the c	ause of death?		
ords	w requires that the been signed by th should be detache	eted by							1 🗆 Y	'es 2	□No 3□P	robably	y 4 Mnknown		
Vital Records,	e la has 3e 2	Completed							24a. Was a autop: perfor	sy	prior to death?	comple	findings available etion of cause of		
<u>=</u>	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. F	Place of Death							
0	Physic this c	၉	1 XYes 2 No	Hospital: 1 Inpatie		/Outpatien		Nursing Hom	e 5 🗌 Resid	ence	6 ∑ Other (Spe	ecify)	at scene		
	ding P h. After funera	ü	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Dat		b. Time of Injury	28c. Injury at Work?	3	St. Describe h		2 11	10	1		
VIVISION	eatt or:	icat	2 Accident investiga 3 Suicide 6 Could no	t be 380 Block of Init	unu At home	t	AM 1 Yes	/	0	,		10			
≥ ⊃⁄	A or Attan after deat Diractor: I in by the	Certification:	4 Homicide determin	ed 28e. Place of Injubulding, etc	c. (Specify)	, iaim, sire	the facility	2	City or Town	n, State		win	oute Number,		
1	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	edical C	(Check only 2 Medical E	caminer: On the basis of	examination	dge, death	occurred at the time, dat estigation, in my opinion,	te and place, ar death occurre	nd due to the c	ausa/s)	and manner a	s stated	d. e cause(s)		
	o the	Med	29b. Signature and title of certifier	and manner sta	ueu.		29c. License numb				te signed (Mon				
,	F 3 F 8		1/11/11	V			OCME				nuary 1				
			30. Name and address of person w	no completed cause of d	eath (Item 2)	a) (Tyne I									
1	And the second second		THEOPOLE MIK	1	(1.0111 2.	, (15po, 1	111 Penn	Street,	Baltino	e, N	1arylan	d 2	1201		
Ė	Sta	e	31. Date filed (Month, Day, Year)		ar's Signatur	e se	a chi s								
	Registra	ar a	JAN 2 0	2004	That ship	Ser Jelia	The Comment of the Co								

State of Maryland / Department of Health and Mental Hygiene 2001

						Cer	tificate of	Death		Reg. No.	14 01002
П	Physici	an	1. Decedent's Name (First, Middle, Last,						2. Date of De Month		3. Time of Death
	/Medic		Emily Busby Locks					AL City Town	Jan.	16 200	
	Examin	er	4a Facility Name (If not institution, give					•	or Locetion of Death	, , , , , , , , , , , , , , , , , , , ,	Death Carroll
	Funeral		Lorien Nursing Ho 5. Social Security Number 6. Sec		(In yrs. last bi	irthday)	If Undar 1 Yea		rs. 8. Date of Birt		Birthplace (State or Foreign Country)
	Director		225-09-5995	M 2⊠F	92	Yrs.	Months Days	Hours M	Dec. 2	9, 1911	Virginia
	D .		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Tov	m or Loc	eation				10d. Inside City Limits
	faryla	5			•						1 ☐ Yes 2 ☒ No
	28a	e c	Maryland Carrol 10e. Street and Number	L		Mt.	Airy 10f. Zip Code			10g. Citizen of Wha	t Country?
	Sa or	Ē	705 Midway Av	re.				21771		United	
	deat me 2	Funeral Director		12. Was Decedent Ev Armed Forces?	er in U,S.	13. W	/as Decedent of Yes, specify Cul	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	14. Race - /	American Indian, Vhite, etc.
22	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			□Yes 2ŽNo		,,	Specify: W	
7700-C1717	2 hou	ted	15. Decedent's Edu	cation	16a	. Decede	ent's Usual Occu	ipation a during most of w		16b. Kind of Busin	ess/Industry
7	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		life. D	O NOT use retire	9d)			
7	led v tygier nt, 15		12th 17. Father's Name (First, Middle, Last)				Office	e Assist	ant ame (First, Middle,		ors Office
		Be c	Kaleb Busby					Mary		tcheson	
	should and Men merks umetic	٩	19a. Informant's Name/Relationship (Ty	pe, Print)	191	b. Mailing	g Address (Stree			er, City or Town, Sta	te, Zip Code)
	Cl		Emily Solomon Gu	ıardian	2	120	Duvall 1	Road Wo	odbine, M	D 21797	
ore,	of He of He fitem		20a. Method of Disposition 1 □ Burial 2 分Cremation 3 □ R	emoval from State	cemete	ry, crem	ition (Name of atory or other pla		Date	20c. Location - City	
Baltimor	Pag Iment Iant: I		4 □ Donation 5 □ Other (Specify)		Carro	/			Jan. 16,	2004 Ham	pstead, MD
Da	permit. Pages 1 and Department of Health important: if item 27 any injury or other tr once.		21 Signature of Funeral Service License	Cill	unh	B		Queen Fu		ectors, P	
			26a. Part1 Enter the disease or complishock or heart failure. List only or	cations that caused th	ne death. Do	not ente	r the mode of dy	JIC LIDE ing, such as card	rty Koad iac or respiratory ar	winiield rest,	Approximate Interval Between
F	Physician		snock or neart failure. List only or								
	/Medical Examiner	ľ	Immediate Cause (Final disease or condition resulting in death)	17/10	rosc i	en	116	ancla	vanuea	N Dipel	
		-	Tosuling in Goalin,	O. C.	ue to (or as a	consequ	ience of):	-100-	Arcide	n Dipec	
	outed id ensit	Examiner	Sequentially list conditions	D.	ue to (or as a	consequ	ience of):	C4017 /	16616661		
Š	e exte	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	thre	W	Abn	Malin	,		
00/00	death certificate be executed e attending physician end ed for use es the buriel-trensi	edicai	that initiated events resulting in death) Last	Du	ue to (or as a	consequ	ence of):				
X	certift ding	Σ									i
0	d for u	Ician	Part II. Other significant conditions con	tributing to death but	not resulting i	n the un	dedving cause g	iven in Part I	23h Did t	obacco usa contrib	oute to the cause of death?
	if the c by the fache	Physician/	Tarrii. Other alganicant conditions con	mbaning to death but	not resulting t	II tile til	denying cause g	on in a diti.			Probably 4 Unknown
'n	es tha igned be de	P							-		
cords,	v requires that the death certificate be executed been signed by the attending physician end should be detached for use es the buriel-trensit	Completed							24a. Was perfor	an autopsy 24 med?	tb. Were autopsy findings available prior to completion of cause
Ū.	2 88 2	d L								/	of death?
	n: The ificate h or. page	ပိ	25. Was case referred to medical					36 Piggs of D	eath (Check only o		1 ☐ Yes 2 ☐ No
>	Physician: this certific rel director.	O B	examiner?	ospital:	2 □ ER/O	utpatient	3□ DOA OI	hor:		ence 6 Other (5	Specify)
5 2	ig Phys ter this nerel di	L ii	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b.	Time of	28c. Inju			ow injury occurred	,,
2	tandir leath. for: Al	catl	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No	006 1		
DIVISION	or At efter of Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. ((Specify)	arm, stree	et, factory, office	1	City or Tow		r Rural Route Number,
	to the hospital or Attanding Physician: initin 24 hours efter death To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	(Check only "2 Medical Examir	ician: To the best of re: On the basis of ex	kamination ar	e, death o	occurred at the t	ime, date and pla opinion, death oc	ce, and due to the c currad at the time, o	ause(s) and manne date and place, and	r as stated. due to the cause(s)
	ithin 2 of the 1	Med	29b. Signature and title of certifier	and manner state	a.		29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
)	£ ≯ ¥ 8		501				D	3064	1	Tanara	16 7004
	13	-	30. Name and address of person who co	mpleted cause of dea	th (Item 23a)	(Type, P	rint),	7-04		2.14.	14/12/43
	\		RIMESH SA	3APATI	47 3	460	Erdne	ar IN	envo /	201111100	14/12/14)
	Sta Registra		31. Date filed (Month, Day, Year)	0 2004 Registrar's	Signature	10	Rogal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dayth Yeer JANUARY 15 2004 **Physician** 03 48 M James Edward Lacv /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-64-8640 Yrs. Director 48 May 4,1955 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 1932 Quentin Road 21222 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status drier . filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 the Modical Exer 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygiel Important: If item 27 is marked other it eny injury or other traumatic event, Illa 2008. 1 Year Electrical Supervisor Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward William Lacy Thelma Louise McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sheryl A. Lacy (Wife) 1932 Quentin Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)
21. Signature of Fundal Service Lice Hilltop Service Corp. 1/19/2004 Towson, Maryland e Lic 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE ORGAN DYSFLINCTION THREE DAYS /Medical Due to (or as a consequence of): Examiner DISSECTION AORTIC FIVE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner MULTIPLE physician and the burial-transit The law requires that the death certificate be executed HYPERTENSION YEARS Due to (or as a consequence of): Box 68760 MULTIPLE ATHEROSCLEROTIC VASCULAR YEARS as by the attending packed for use as IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ as been si 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No autopsy performed3 page certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation М death 2 Accident s after death Il Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Dir the Hospital 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Algano

AL ADDASI, MD

Actours

2 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

magazin k

AL ADDASI, MD

32. Registrar's Signature

SURGICAL RESEDENT

29c. License number

DEPARTMENT OF SURGERY - UNION MEMORIAL HOSPITAL
BALTIMORE, MD 21218

HT-2438946-P41

201 EAST UNIVERSITY MARKWAY

29d. Date signed (Month, Day, Year)

JANUARY 15th 2004

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary		Certifica			-	Reg. No. 2	n.	01001		
	Physici	_	1. Decedent's Name (First, Middle, Last)						2. Dete of Dec	eth Day	Year	3. Time of Death		
	/Medic	al .	JESSE 4a Fecility Neme (If not institution, give st	reet end number)		LE:	SSER	4b. City, Town, or	JANUARY Location of Deeth			2:42 P		
ı	Examin	er	NORTHWEST HOSPITAL						NDALLSTO	NMN		BALTIMORE		
	Funeral Director			M 2□ F	yrs. lest birt 80	thday) If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min.		, 1923	9. Birthp Cour	lace (Stete or Foreign try) MD		
	ylend wor		Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town	n or Location					1	Od. Inside City Limits		
	Be-fet	ctor	MD BALTIM	ORE	BA	LTIMORE						1 ☐ Yes 2 ☑ No		
	with the	Funeral Director	9 POMONA SOUTH #8			10f. Z	ip Code	21208		10g. Citizen of V		J.S.A.		
	death	nera		2. Was Decedent Ever Armed Forces?	r in U,S.	13. Was Dec	edent of h	Hispanic Origin? (S en, Mexican, Puer	Specify Yes or No	- 14. Raci		an Indian,		
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health and Martel Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28e-f ehow says injury or other traumetic event, the Medical Evantment must be notified at ance.		1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		1 □ Yes	2 ∏ №	Specify:		Specify	*	WHITE		
<u>.</u>	in 72 h	Sete	15. Decedent's Educa (Specify only highest grede	completed)	16a.	Decedent's Us (Give kind of w life. DO NOT	ual Occuj rork done use retire	oation during most of wo d)	rking	16b. Kind of Bu	/siness/Ind	dustry		
212	giane.	Completed by	Elementery/Secondary (0-12)	College (1-4or 5+)	SEL	F EMPLO				REAL E	STATI	/ FINANCE		
and	be file ad other	Be	17. Fether's Name (First, Middle, Last)		ı E	CCED			me (First, Middle,	Maiden Surnam	,	OTHCUTI D		
يج	should nd Mar marke	٥	ANTHONY 19a. Informant's Name/Relationship (Typ)	e, Print)		SSER . Mailing Addre	ss (Street	GOLDI and Number or Ri	DIE ROTHCHILD or Rurel Route Number, City or Town, Stete, Zip Code)					
ž	end 2 saith e 1 27 is		STUART M. LESSER /					LANE - T	Transport.					
Jore	uges 1 or oth		20a. Method of Disposition 1	movai irom state		Disposition (N y, crematory or RIDGE (Date	20c. Location -	-			
altimore,	nit. Pa artmar ortant: in ury	1	4 Donation 5 Other (Specify) 21. Matrix of Funeral Services Licensee		EKY ess of Fecility SO	1/16/04 L LEVINS			LE, MD					
m	Dep Sany		Willand Druge	,	ERSTOWN	ROAD - P	IKESVIL							
			23a. Pert1. Enter the diseese of complic shock, or heart failure. List only one	ations that caused the cause on each line.	deeth. Do r	not enter the mo	ode of dyi	ng, such as cardia	c or respiratory e	rest,	1	Approximate Interval Between Onset and Death		
	Physician /Medical	Н	Immediate Cause (Final	A .	£	ny och	1-	0 - 1	mchin		1			
	Examiner		disease or condition resulting in death) e.	Due	to (or es e	ognsequence of	f):	, my	minn					
I	nsit	mine	b.	Kes	mirat	consequence	on l	m			i 			
oʻ	e axeo	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Sw	-cre	luja	hil	imen						
68760,	ificate be axecuted g physicien enc es the buriel-transit	edical Examiner	that initieted events resulting in death) Lest	Due	to (or es e c	onsequence of):				1			
		_	d.											
B	e daati the ette	sicia	Part II. Other eignificant conditions conti		ot resulting in	the underlying	cause gi	ven in Part I.	23b. Did 1	tobacco use cor	ntribute to	the cause of death?		
<u>Ч</u>	that the	y Ph	3/1 la Prestati	<u> </u>					1 🗆	Yes 20 No	3 □ Prol	babiy 4 ☐ Unknown		
Division of Vital Records, P.O. Box	The law requiras that the death certificate be assouted at a been signed by the ettending physicien encage 2 should be detached for use as the buriel-transit	Completed by Physician/M	Elminic bad	h più						an autopsy med?	av.	ere autopsy findings ailable prior to mpletion of cause death?		
- B	The la	Comp							101	ras 25/No	1£]Yes 2□ No		
Vita	Iclan: certific ractor,	Be	25. Was case referred to medical examiner?	ospital:			Oti	hor:	ath (Check only o					
0	Phys ar this eral di	n: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Dey Ye	28b. T	tpatient 3 l	28c. Inju Wo	4 🗆 I VUI SIII G I	łome 5 🗆 Resid 28d. Describe I	dence 6 ∐Othe now inj <i>u</i> ry occ <i>u</i> rr		у)		
ion	anding seth. or: Afte	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			njury M	1	Yes 2□No						
<u>X</u>	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha complataly filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S	- At home, fa Specify)	rm, street, facto	ory, office		28f. Location (S City or Tox		er or Rura	il Route Number,		
	Hospit. 24 hours Funera taly fille	edical	29a. Certifier (Check only one) Certifying Phyel	cian: To the best of mer: On the basis of exe end manner steted	eminetion en	, deeth occurre d/or investigation	d et the ti on, in my	me, date end place opinion, death occi	a, and due to the urred et the time,	ceuse(s) and me date and plece, e	nner as s end due to	tated. the ceuse(s)		
	ro the	Me	29b. Signature and title of certifier	\	•	2	9c. Licens	se n <i>u</i> mber		29d. Date signed				
			Muls) ms			2	15938		1/13	104			
	15		30. Name end address of person who con 5400 OLD COUR			(Type, Print) すとしょ かい	~~	md 2i	133					
	Sta		31. Dete filed (Month, Dey, Year)	3. Registrar's	Signature	Charles								

DHMH 16 Rev 6/95

		1 - State of Ma	aryland / Dep <i>Ce</i>	artment of He			ene 2001	: 01085	
Physi /Med	cian dical		ANLEY	LAYTON		2. Date of Death Month JANUARY	$^{\prime}$ 15 , 2004		
Exam	al	4a. Facility Name (If not institution, give street and number) 6615 WICKFIELD ROAD 5. Social Security Number 215-14-4303 6. Sex 1 M 2 F	e (In yrs. last birthday, 80 Yrs.		LTIMORE	8. Date of Birth (Month, Day, JULY 18		TIMORE pplace (State or Foreign untry)	
Directo	or	Usual Residence of Decedent	10c. City, Town or L	ocation		JULT 10,	,1923	MD 10d. Inside City Limits	
h the Mary r 28a-f ah r rotified	Director	MD BALTIMORE 10e. Street and Number	BAL	TIMORE 10f. Zip Code		10	g. Citizen of What Co	1 □ Yes 2 ☑ No untry?	
III. X I X I 3-0030 be filed within 72 hours after death with the Maryland tital Hygiene. Ind other than "natural", or tems 23a or 28a-f ahow event, its Medical Examiner matter rectified at	Funeral D	6615 WICKFIELD ROAD 11. Marital Status 1 Never Married 20 Married 12. Was Decedent I Armed Forces? 1 X Yes 2	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	21209 panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
2-0030 72 hours af natural, or	b	3 Widowed 4 Divorced Yes, Give Yes or Opates: 15. Decedent's Education (Specify only highest grade completed)	16a. Dece	1 Yes 2 No	Specify: tion uring most of working	ng 1	Specify: 6b. Kind of Business/	WHITE	
illed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12) College (1-4or 5 12) 17. Father's Name (First, Middle, Last)	life.	DO NOT use retired) OPER	18. Mother's Name	F	REAL ESTATI	Ε	
g da da ∳	To Be	MORRIS 19a. Informant's Name/Relationship (Type, Print)	LAYTO	ON	SARAH		· ·	ECHOLEUSKY	
E, ING 1 and 2 4ealth a em 27 le		SHIRLEY LAYTON / WIFE 20a. Method of Disposition	20b. Place of Disp				RE MD 212 0c. Location - City or		
permit. Pages Department of H Important: If ite any injury or of	once.	1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Gervice Licensee		1UNO ARLING 2. Name and Address	of Facility SC	L LEVINS	ON & BROS	., INC.	
Physicia		23a. Part1. Enter the lise set of complications that caused shock, or hea vailure list only one cause on each lir immediate Cause Final disease or condition	the death. Do not ente.	nter the mode of dying	, such as cardiac o	or respiratory arres	IKESVILLE odg	Approximate Interval Between Onset and Death	
/Medica Examine	er	Sequentially list conditions.	a consequence of):				0	1	
ate be executed hysician and the burial-transit	Jicai Examine	Cause (Disease or injury that initiated events c.	a consequence of):						
.O. DOX OS/10 The death certificate by the attending physical properties of the terminal physical phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year	
w requires that the death been signed by the attershould be detached for	b	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giver	n in Part I.		acco use contribute to a 2 ¼ No 3 ☐ Pri	the cause of death?	
The lar ate has page 2	Completed	INCONTINENT DENT DE TIMMOSILITY SYNOR	one,	5 blade	der	24a. Was an autopsy perform 1 Yes 2	prior to d	topsy findings available completion of cause of	
ysicia ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie		ent 3 DOA Other	4 Nursing Hor	me 5 Resider	nce 6 Other (Spec	city)	
r g in in in in in in in in in in in in in	ertification:								
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	O	4 Homicide determined 200. Flate of in building, et 29a. Certifier (Check only 2 Medical Examiner: On the basis of	of my knowledge, dea	th occurred at the time	e, date and place,	City or Town,	use(s) and manner as	stated.	
To the Ho within 24 To the Fu	Medical	29b. Signature and title of certifier	ated.	29c. Ligense	number 4 74	19 29	d. Date signed (Monti	n, Day, Year)	
10		30. Name/and address of derson who completed cause of	eath (Item 23a) (Type	Benson	s Ave	Balti	nore, I	MO 2122,	
	State	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	A. a. M.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** :10AM TANUARY 15, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE SAMARITAN (000) HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□F Days Hours 220-22-733 Director Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYIAND mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DURN Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 TYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 1Ack Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the May any injury or other traumatic event, the May Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Chy or Town, State, Zip Code) LARRIJE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22/04 m 21. Signature of Funeral Service Licensee 22 Name and Address W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YO CARDIA! INFARCTION /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate has autopsy performed 1 ☐ Yes 2- No 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After A safter dea. 1 -Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD KES 000 ANUARY 15, 2004

State Registrar

DHMH 17 Rev 1/2001

RAVEN

BLUD

BALTIMORE,

MD

2123

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lock

22 Registrar's Signature

5 601

MD.

ISSA

31. Date filed (Month, Day, Year)

		1 - For State Registrar 1. Decedent's Name (First, Middle, La	(st)		ertificate of	Death	Reg. 2. Date of Death	. No. 2004	3. Time of Deatl
Physici	an	William B. Ma					Month	Day Year	7:15 P.
/Medio		4a. Facility Name (If not institution, gir			4b. City, Town, o	or Location of Death	Juli. II	4c. County of Dea	th
Examil	lei	Future Care			Arnold			Anne Aru	undel
Funeral Director			· □ · · □ ·	(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 7,	9. Bir Co 1907 V	thplace (State or Fore ountry) irginia
3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Lim
sho i	ō	Maryland Anne A	runde1	Arnolo					1 □ Yes 2 🔼
28a-	rect	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
3a or	0	305 College Park	way		210	12		United S	tates
ms 2	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
it of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	1 □ Yes 2 □Xio		Tribati, dio.y		White
natu	etec	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	pation during most of work	ing 16	b. Kind of Business	/Industry
han.	Completed	Elementary/Secondary (0-12) 6th	College (1-4or 5-	+)		nd)		- 61-1-1	G. 1
Hygie thert nt, th	ပိ	17. Father's Name (First, Middle, Las	()	bree	l Worker	18. Mother's Name	e (First, Middle, Ma	ethlehem iden Sumame)	Steel
ed of	Be.	James Thomas	•				Herring	,	
nark matic	င္	19a. Informant's Name/Relationship	(Type, Print)	19b. N	lailing Address (Street			City or Town, State,	Zip Code)
Ith ar 27 is r trau		Alvin A. Mars	shall/ Son		O.Box 3927				
Department of Health a Important: If itsm 27 is any injury or other tra		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla		Date 20	c. Location - City or	Town, State
ant of		1 ABurial 2 ☐ Cremation 3 l		BelAir	cremetory or ourer pla	1-14-	-04 B	elAir, Md	1.
ortant: injury		21. Signature of Funeral Service Lice	• •		22. Name and Addre	ess of Facility			
Depa Impo any ii		Murufalle	Ellan T	MOCHO	2134 Will	ow Spring	Rd Ralt	erar nome o Md 21	222
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e attending phy od for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of the birth depregnant at 9 Unknown	2 Fetal death time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _			23d. Date of de Month	Day Year
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has Je 2	Completed						24a. Was an autopsy performe	d? death?	utopsy findings avail completion of cause s 2 No
certificate rector, pag	Be (25. Was case referred to medical examiner?					h (Check only one)		
r this certific	2	1 ☐ Yes 2 No	1	nt 2 ER/Outp	atient 3L DOA	W15 1779	ome 5 Resident		ecity)
Afte	Certification:	27. Manner of Death Natural	be 200 Place of Inju	iry at ork?]Yes 2 □ No	28d. Describe how 28f. Location (Stre		Pural Route Number,		
rrs after deat ral Director: lled in by the		4 Homicide determine	building, etc	:. (Specify)			City or Town,		
Funeral Funeral tely filled	edical		Physician: To the best of sminer: On the basis of and manner sta	examination and/					
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within 2 To the	1			1 1 1 3				11101	
within 24 hours after To the Funeral Dire completely filled in b		30. Name and address of person wh				40519 a, Suite		1/13/	

			1 - For State Registrar	State of Maryland		artmeni <i>tificate</i>			and M		ene 0	0 1	0 1	088
	Dharais		1. Decedent's Name (First, Middle, Las	t)						2. Date of Death			3. Tim	e of Death
	Physic /Medi		JAMES B. A	NANN						Month	Day 18	Yeer	4:7	20 PM
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City,		Location o			4c. Count	y of Death		
	3			1 4 4 1 1 1 1 1	PITAL			LTIN		E	Br	AL TI	MO	RECT
	Funeral Director		SILO IN SILVE IN	7. Age (In yrs. la ZIM 2 F	Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Cour	place (Stantry)	te or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation							Od Inside	e City Limits
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other then "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinational Eurorilling and	Funeral Director	MD		0	Otin		2					1.	es 2 □ No
	with the or 3	F	10e. Street and Number	ohan A.		10f. Zip		1711	,	100	g. Citizen of	What Cour	itry?	
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36	or Iten	y Fun	1 Never Married 2 Married	Attried Forces?		Yes, speci	1/	Specify:	, Puerto i	cify Yes or No- Rican, etc.)	Bia	ce - Americ ick, White,		,
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	other other	Be C	17. Father's Name (First, Middle, Last)		Jidee	7.0010		18. Mother	r's Name	(First, Middle, Ma	iden Sumai	ne)	. I LCP	
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Baltimore,	0 0		20a. Method of Disposition 1		nce of Dispos metery, crem	sition (Name	e of her place)	D	ate 20	c. Location	City or To	wn, State	
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3ali	permit. Pa Departmer Importent any injury		21. Signature of Funeral Service Licens	90 1	22.	Name and	Addres	of Facility	BAL	TIMORE	mo	212	34	
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Division	I or Attending after death. Director: After I in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e, farm, stree				28	If Location (Stree	t and Numb	er or Rural	Route No.	mher
É	s after a ster it Dire	ert	4 Homicide determined	building, etc. (Specify)		7,				City or Town, S	tate)	or or ribrar	70010740	imber,
	Hospitsi 24 hours a Funerel I stely filled	Salc	29a. Certifier 1 Certifying Physical Examin	sicien: To the hest of my knowle	edge, death .	proumad at	the time	, date and	place, an	id due to the caus	e(s) and ma	กกอกสร สส	ted.	
		edicai	one)	ner: On the basis of examinatio and manner stated.	n and/or inve	stigation, in	n my opir	nion, death	occurred	d at the time, date	and place, a	and due to	he cause	r(s)
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,	1.	100	Malhan			R	ES 1	000			1/18	104	4	
	20		30. Name and address of person who co			rint)					t:	200		
	7		ZEEBA MATHEWS 31. Date filed (Month, Day, Year)	5, 5601, Loc	HRAV	EN	BLY	VD,	BA	LTIMOR	È,	MD	212	-39
3	Star Registra		JAN 2 0 2004	32 Registrar's Signatur	· Anna	18								

			For State Registrar	State of M	larylan				lealth a Death	and M		jiene	2004	01	089
		-1	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	th Day	Yeer	3. Time of	Death
	Physici /Medic		Teri Davis McGe	eney							January		2004	6:40	a ^M
1	Examin		4e. Fecility Name (If not institution, give)	1	4b. City,	Town, or	Location of	of Death			ounty of Deeth		
			412 Stemmers Run				Esse	_	14 Under	04 Hen			ltimore		
	Funeral		5. Social Security Number 6. S	ex		last birthday) Yrs.	If Under Months		If Under Hours		8. Date of Birth (Month, Dey Sept. 1,	Year)	Cou	place (Stete o	r Foreign
	Director	ļ	212–68–1911		47				<u>.</u> i		sept. I,	1956	Mary	land	
	land		10a. State 10b. County	· · · · · ·	10c. Cit	ty, Town or Lo	cation							0d. Inside Ci	ty Limits
	Mary Hash	ţ	Maryland Baltimor	re	Ess	sex								1 🗌 Yes	¾ XNo
	1 the	iec	10e. Street and Number				10f. Zip	Code		-1	1	log. Citize	en of What Cou	ntry?	
	h witi	a D	412 Stemmers Run F	Road				2122	1			U.S	S.A.		
	deat	Funeral Directo	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	l.S. 13. \	Vas Deced	dent of Hi	ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14	I. Race - Ameri Black, White,		
9	or Ite	E	1 Never Married 2 Married	1 ☐ Yes 2 2 If Yes, Give		į	Yes		Specify:	,	,		Specify:		
21215-0036	within 72 hours atter death with the Maryland ene. than 'natural', or items 23s or 28s-f show ta Madical Examirer mast by notified at	Completed by	3 Widowed 4 Divorced	Year or Dates	:	,							Whit		
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lan	id be ental ked o	m	Francis Robert Sou	ıles					Gra	ce Le	ehman				
Maryland	should be fand Mental Is marked of	ļ-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street	and Numbe	er or Rura	Route Number	r, City or	Town, State, Zip	Code)	
	Health a tem 27 ls	9	Joseph E. McGeeney	/ (Husband	d)	412 5	Stemm	ers 1	Run R	oad,	Baltim	ore,	Maryla	nd 2122	21
ore,	of He of He I Item		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Bamaual from Stat		Place of Dispo	sition (Nar	me of other plac	e)	D	ate	20c. Loc	ation - City or Te	own, State	
Ĕ	Pages nent of ant: If It		'4 □Donation 5 □ Other (Specific		Pa	rkwood	Ceme	tery	J	an.19	9,2004	Balt	imore, 1	Marylar	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Madical Examinal read the notified at ODGs.		21. Signifure of surreyal Sen of Licer	1500		22	. Name an	nd Addres	ss of Eacilit	hski	Funera	l Hor	me, P.A. , Maryla		
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r			23a. Pert1. Enter the disease, or com shock or heart failure. List only	plications that cause one cause on each	ed the deat	th. Do not ent	er the mod	de of dyin	g, such as		-			Approximate Interval Bette Onset and I	ween
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	/Medical Examiner		resulting in death)	Due to (or a	s a consec	quence of):	1								
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	ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	A CONSEC		-11	2.7							
	and and II-tran	xan	that initiated events resulting in death) Last	Dug to for a		They	V	/	_						
8760,	cate be executed obysician and the burial-transit	cai E		Flde	PNOC	IAVE	Non	nA.	13	CA	5+				
687	ficate physis the			d		277 -1									
XO	death certific e attending pl nd for use as t	Physician/Med	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcom								23	d. Date of deliv	ery	
m	death a atte	icia	in the past 12 months? 1 □ Yes 2 0 No	1 ☐ Live birth 4 ☐ Pregnant]Ectopic pi] Other (sp						Month	Day h	/ear
O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown											
٥,		by P	Part II. Other significant conditions of	contributing to death	but not res	sulting in the u	nderlying o	ause give	en in Part I		23e. Did to	bacco us	e contribute to t	he cause of d	eath?
ğ	v require been sig should b										1 🗆 Y	es 2X	No 3□ Prol	ably 4 □L	Inknown
Records	law requires as been sign 2 should be	Completed									24a. Was a autops		24b. Were auto	psy findings a	
ž	0 = 0	E									perfor	med? 2 X No	death?	2□ No	2000 07
Vital	ician: Th certificate rector. pag	Be C	25. Was case referred to medical examiner?			-				of Death	(Check only or	10)			
of V	Physician: this certific ral director.	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatier			4 🗆 NU	irsing Hon	ne 5 Resid	ence 6	□Other (Special	y)	
u o	ng P	- i	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, E	jury Jay Year)	28b. Time of Injury		28c. Injun Worl			28d. Describe h	ow injury	occurred		
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b			1	М		Yes 2□		201 1 10				
Division	after d Direct In by	Certification:	4 Homicide determined	28e. Place of I	njury - At n etc. <i>(Speci</i>	i fy)	eet, factor	y, office		2	City or Tow		Number or Run	ai Houte Num	oer,
	To tre-Hospital or Attending Pattin 24, hours after death. To the Funeral Director: After completely filled in by the funer		29a, Certifier Certifying Pt	Aveician: To the her	at of my kn	audodno dosti	3.000	at the tre	no data as	d elege a	and due to the	222(2) 2	ad margar as a	tatad	
	Hospital	edical	(Check only 2 Medical Examone)	nysician: To the bes miner: On the basis and manner:	of examina	ation and/or in	vestigation	n, in my o	pinion, dea	ith occurre	ed at the time, o	late and p	lace, and due t	tated. o the cause(s)
/	o the	Me	29b. Signature and title of certifier	0/1	014104		290	c. Licensi	e number		, 2	29d. Date	signed (Month,	Dey, Year)	
	- 3 - 3		1/1/100	FIA	37	MD		7	06.0	25	4	11	16/0	4	
•	\ -		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type	Print)	1	C & C		•				
			William D.	JONES	rn T	6	131	Sh	soly	Su	7 le 12	al	2070	4.	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	str S Sign	ature	R		(
	Regist		JAN 2	U 2004	Of Mary	30 13	A STATE OF	mer.							

			For State Registrar	riedse		Maryland / D	epartment of light of the control of	Health and I	Mental Hy		nn.	01000
			Decedent's Name	(First, Middle, La	ist)				2. Date of De	ath	O G G	3. Time of Death
	Physic		Carolyn i	Ann Mur	ray				Vanuary	Day	2004	7:40PM
	/Medi Exami		4a. Facility Name (If	not institution, gi	ve street and numb	ber)	4b. City Jown,	or Location of Death		7	unty of Death	
			Frankli	n Sauce	re Hosp	ital	Kos	edale		Bai	Himor	e
	Funeral		5. Social Security Nu		Sex 7. 1 □ M 2 🖾 F	. Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs.		th ly, Year)	9. Birthp	lace (State or Foreign (ny) Land
	Director		213-32-06	56	1 M 2 2 2	70 Y	·s.		Jan.31	,1933	Mary	Länd
	and wo		Usual Residence of 10a. State	10b. County		10c. City, Town	or Location				10	Od. Inside City Limits
	Mary f sho	ğ	Maryland	Baltimo	re	Overle	a					1 ☐ Yes 2 ∑ X¶o
	r 28a	Director	10e. Street and Num	ber			10f. Zip Code			10g. Citizen	of What Coun	itry?
	death with the Maryland ms 23a or 28a-f show Liviust be notified at	a D	521 Elmwo	od Road			2120	16		U.S.	Α.	
	r dea	Funeral	11. Marital Status		12. Was Decede	ent Ever in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No to Rican, etc.))- 14.	Race - Americ Black, White,	
	36 safte	Y.	1 Never Marrie	_	1 ☐ Yes 2 If Yes, Give	XXIV0	1 ☐ Yes 250MNo				ecify:	
	000 hours tural	ed by	3 Widowed	15. Decedent's E	Year or Date		Pecedent's Usual Occur	pation		16h Kind	WI of Business/Inc	nite
>	15 in 72	ojet	(Ѕресіі	fy only highest gr	ade completed)	100. (Decedent's Usual Occu Give kind of work done life. DO NOT use retire	e during most of wor ed)	rking	TOD. KING	or Dusinessymic	lustry
0	212 d with giene.	Completed	Elementary/Secon	idary (0-12)	College (1-4		Pianist			Peabo	dy Inst	titute
arolyn	e file othe vent,	Be C	17. Father's Name (i	First, Middle, Las	t)			18. Mother's Nan	ne (First, Middle,	, Maiden Sur	mame)	
(-)	/lal	0	Henry Sch	iffler				Ann S	taehlin			
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinatives by nutified at any injury or other traumatic avent, the Medical Examinatives by nutified at once.		19a. Informant's Nat James W.				Mailing Address (Stree					
7	s t ar f Hea item other		20a. Method of Disp	osition		20b. Place of I	Disposition (Name of crematory or other pla	ace)	Date		ion - City or To	
Murray	Baltimore, permit. Pages 1 a Department of Her Important: If item any injury or other page.		¥⊠8urial 2 ☐ `4 ☐ Donation		□Removal from St fy)	Immanue	el Lutherar	Cem Jan.	.20,2004	Baltin	more, M	aryland
2	alti rmit. partm poorta y inju		21. Signature of Fur	neral ervic Lice	nsee	. /	22. Name and Addr	ess of Facility Bruzdzinsk	ki Funer	al Hom	ne, P.A	
5	m 88 5 5 8		7	- 12	704		22. Name and Addr 1407 Old	Eastern A	Avenue,	Essex,	Maryla	and 21221
			23a. Parril. Enter th shock or hear	e disease, or cor t failure. List only	nplications that cal or e cause on eac	sed the death. Do no th line.	t enter the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (I disease or condition resulting in death)	Final 1	a Acu	te my	cardia	IInfa	retion			Shipot and Dodge
	/Medical Examiner		resulting in death)	•		r as a consequen a):					
		5	Sequentially list con	ditions,	b. Due 10 (0.	Umoni	9				-	
	uted I Insit	Examiner	if any, leading to importance. Enter Under Cause (Disease or inthat initiated events	flying njury	·							
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	- U - O	cai			d							
	Records, P.O. Box 68 The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE:									
	30) ath ce ttendi	lan/	23b. Was decedent in the past 12 r		1□Live birt	ome of pregnancy th 2 DFetal death	3 □Ectopic pregnanc	су		23d.	Date of delive Month	ry Day Year
	cords, P.O. Be wrequires that the death been signed by the attershould be detached for	/sic	1 ☐ Yes 2 🗶		4□Pregnar 9□Unknow	nt at time of death vn	5 Other (specify)					,
	P.O.	F.		cant conditions	contributing to dea	th but not resulting in	he underlying cause gr	iven in Part I.	23e. Did to	obacco use o	contribute to th	e cause of death?
	ds, lires sign	d b	Hel	Datie	fai	lure	, , ,		1)(1)	Yes 2□N	lo 3 ☐ Proba	abiy 4 ∐Unknown
	Krequ been shoul	ete	1Qa	10	Rer	2 10	ailure		24a. Was	an 2	4h. Were autor	osy findings available
	Re(he lav	E G	- 1100	J1C	1701	141	arrore		autop	osy ormed?	prior to con death?	npletion of cause of
	Vital Recidinari The lave	ပိ	25. Was case refern	ed to medical				26 Place of Dea	1 ☐ Yes ath (Check only o	2 X No	1 🗆 Yes	2∐ No
	f Vital Re ysician: The lav is certificate has director, page 2	0 8	examiner?		Hospital:	patient 2 ☐ ER/Outp	patient 3 DOA Ot	hor	lome 5 ☐ Resid		Other (Specify	0
	Division of Vital Records, at or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Ë	27. Manner of Death		28a. Date of	Injury 28b. Ti	ne of 28c. Inju		28d. Describe			,
	isior ttendin death. ctor: Att	atio	1 Natural 2 Accident	5 Pending investigation	on	, buy rous,		Yes 2 □ No				
	ivising rate recter de recte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	286. Place of	f Injury - At home, farr g, etc. (Specify)	n, street, factory, office		28f. Location (S City or Tox		umber or Rural	l Route Number,
	rital o				W.			//				
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directorial	Medical	29a. Certifier (Check only one)	1X Certifying P 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examination and	death occurred at the to for investigation, in my	time, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and date and pla	d manner as sta ce, and due to	ated. the cause(s)
	To the I within 2 To the I	Me	29b. Signature and	title of certifier	State .			ise number			gned (Month, L	
	6		126	1 Ju	em	-	4.D. Da	b\$ 5647	77	1-	17-20	004
	6		30. Name and addre	ess of person who		of death (Item 23a) (T	ype, Print)	^ '	0	1.1.		7 21237
			VI Glen	101.0	ninger	1000 150	unblin Squ	are Driv	e ba	Itimo	re MI	1 2173/
	Si	ate	31. Date filed (Mont	JANZ	U ZUU432. HO	distrar's Signature	Coarle					

			State of Mary 1 - State Registrar	land / Depa <i>Cei</i>	artment of Heali rtificate of Dea	lth and Me ath		iene 2004	01091
	Physici	an	1. Decedent's Name (First, Middle, Last) David R. Menikheim			_	2. Date of Deat Month	Day Yeer	3. Time of Death
	/Medic		4e. Fecility Name (If not institution, give street and number)		4b. City, Town, or Loca		anuary	16, 2004 4c. County of Deat	11:30 A ^M
	Examin.		Stella Maris Hospice		Timonium			Baltimore	County
	Funeral Director		219–34–4663 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	yrs. last birthday) 62 Yrs.		ours Min.	Date of Birth (Month, Day, larch 19	Year) Co.	nplace (Stete or Foreign untry) Yland
	land w		Usuel Residence of Decedent 10a. State 10b. County 10c	c. City, Town or La	cation				10d. Inside City Limits
	Marylan B-f ehow	tor	Maryland Carroll County	Manchest	ter				1 □ Yes 2 □ No
	death with the Maryland me 23a or 28a-f show	Director	10e. Street and Number		10f. Zip Code		11	0g. Citizen of What Co	untry?
Ė	Jeath v	Funeral	5116 Roller Road 11. Marital Status 12. Was Decedent Ever	in U.S. 13.1	21102 Was Decedent of Hispani	ic Origin? (Speci	fy Yes or No-	USA 14. Race - Ame	
22 a. 036	be filed within 72 hours after death with the Maryla ntal Hygiene. Ad other than "natural", or Iteme 23a or 28a-1 ehov event, the Madical Examiner is use the notified at	þ	Armed Forces? 1 Never Married XX Married 1 Yes 2/XNo 1 Yes 3/6 Never Married 2 Married 1 Yes 3/6 Never Married 1 Yes 7/6 Never Married		1 Yes, specify Cuban, Me	exican, Puerto Ri ecity:	ćan, etc.)	Black, White	hite
10:55 215-0036	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	,	16b. Kind of Business/I	
7 5	be filed within 72 hours after tal Hygiene. d other than "natural", or ite event, ine Macical Exterior	Completed	Elementary/Secondary (0-12) Cotlege (1-4or 5+)	Fore	nan			Baltimore G Electric C	as & o.
2004 land 2	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Men	To Be	17. Father's Name (First, Middle, Last) LeRoy Menikheim	•	18. N	Mother's Name (Betty		Maiden Sumame)	
Mary Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street and N			TARREST TO STATE OF THE STATE O	1
	of Health item 27		Janet Menikheim (Wife) 20a. Method of Disposition 2	Ob. Place of Dispo	Roller Road	d Manch		Maryland 2	
JANUAKI altimore.			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)		natory or other place) v Memorial F	Pk 1/20/	04 5	Sykesville,	MD
JA Balti	permit. Page Department o important: If any injury or once.		21. Signature of Toneral Service Live see	I	. Name and Address of F Burgee-Henss	s-Seitz	Funeral	Home, Inc	
			23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		3631 Falls R	Road	Baltin	ore. Maryl	and 21211 Approximete Interval Between
	Physician		Immediate Cause (Final disease or condition CAN						Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a co	nsequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	nsequence of):					
	cate be executed physicien and the burial-transit	Examiner	Cause (Diseese or injury that initiated events c	neadhanca of).					
8760.	e be ex sicien e buria	dical E	d d	isoquorico ory.					
9		Medic	IC CENAL C.						10-40-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of principle in the past 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of deli	very Day Year
9 0	the de by the a	hysic	1 Yes 2 No 4 Pregnant at time 9 Unknown	ordeath 5	Other (specify)				•
S. P	res that the de signed by the a I be detached to	by P	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause given in F	Part I.		acco use contribute to	
Record	w require been sign	Completed	HEMORRHAGIC STROKE				· · · ·	s 2 No 3 Pro	
Rec	he law e has l	jdmo					24a. Was ar autopsy perform	y prior to c ned? death?	opsy findings available ompletion of cause of
Vital		Be C	25. Was case referred to medical examiner?		26. F	Place of Death (X No 1 ☐ Yes	2 No
of V	Physic this ce al dire	은	1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient	2 ER/Outpatien				nce 6 NOther (Spec	(fy) HOSPICE
on	ding Ith. : After s funer	tion	27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Yei	er) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		a. Describe no	w injury occurred	
Division	or Attendiate death. Director: A	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, str pecify)	eet, factory, office	28	f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	pital c ours af ierai D filled ir		29a. Certifier 1X Certifying Physician: To the best of my	v knowledge death	occurred at the time day	ate and place or	d due to the co	IIea/e) and manner	etated
1	To the Hospital or Attending Physicien: within 24 hours after death. Qo the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only one) 2 Medicat Examiner: On the basis of examiners and manner stated.	mination and/or in	vestigation, in my opinion	n, death occurred	at the time, da	ite and place, and due	to the cause(s)
	withii	×	29b. Signature and title of certifier		29c. License num		29	ed. Date signed (Month	. Day, Year)
7	(3)		7 / 7 -	(Itom 22a) (T	D 43	125		1/16/0	4
	")		30. Name and address of person who completed cause of death DR. TARIO MAHMOOD 2300 DUL	ANEY VAL		MONIUM,	MD 2109	93	
	Sta Registi		31 Date filed (Month, Day, Year) 32 Registrar's S						

JANUARY 16, 2004 10:55 a.m.

DAVID MENIKHEIM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2004 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth IMONIE 8. Date of Birth (Month, Day, Yeer) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Sex AZM 2□ F Birthplace (Stete or Foreign Country) Days Yrs 214-34-0337 66 JAN 6, SOUTH CAROLINA Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1924 SWANSEA 21239 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade ALMAG CHEMICAL CO PLATER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY MCFADDEN LOUISE MCCALLISTER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Minnie M. McFadden/Wife 1924 Swansea Rd., Baltimore, Maryland 21239 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 01-19-04 BALTIMORE, MARYLAND 21. Signature Inneral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Death (Check only one) examiner? Hospital: → Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 211 No 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturel 5 Pending Injury 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be 2

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours eftar deeth with the Marylend Department of Health end Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner attending physician and d for usa as the bunal-transit signed by the ģ Completed Be 10 Certification:

The lew requiras that the daath certificate be axecuted Division of Vital Records, P.O. Box 68760 ceta has been sig this certificeta or Attending Physician: After To the Rospital or Attendir within 24 hours after death.

To the Funeral Director: Af completaly filled in by the fu death.

6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 5 32. Registrar's Signature

Registrar

edicai

29a. Certifier

			1 - For Stata Registrar	Sta	ite of Man	yland	-			ealth a Death	and M		Reg. No.	004	01093
	Physici /Medit Examir	cal	Decedent's Name (First, Midden GRADY MC 4a. Facility Name (If not institution)	CALLEN	and number)					Location o	of Death	2. Date of De Month JANUAR	Day Y 11 2 4c. Coun	Year 004 ty of Death	3. Time of Death 2:15 p
	Funeral Director		1701 EUTAW PI 5. Social Security Number 216-18-3268 Usual Residence of Decedent	ACE A 6. Sex 1 M M 2		n yrs. last	birthday) 3 Yrs.		ALTIM or 1 Year Days	IORE If Under: Hours	24 Hrs. Min.	8. Date of Birn (Month, Da FEB 3	h y, Year)	Cour	olace (State or Foreign htry) JTH CAROLINA
	the Maryland 28a-f show coliffied at	Director	10a. State 10b. Count	/A	10		own or Lo ltimo	re	p Code				10g. Citizen o		0d. Inside City Limits 1X Yes 2 □ No
036	72 hours after death with the Maryland natureli, or itema 23a or 28e-f show dical Examinet must be notified at	by Funerai	1701 EUTAW P 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Wa	2T 525 as Decedent Evened Forces? Yes 2 A No 'es, Give ar or Dates:	er in U.S.			21217 edent of Hi ecify Cuba		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	U.S.	A. ace - Americ ack, White,	ean Indian, etc.
1215-0036	within ane. than "	Completed	(Specify only higher Elementary/Secondary (0-12)	T	oleted) llege (1-4or 5+)	1	(Give life. l	kind of w DO NOT	ise retired,	furing most)		ng	16b. Kind of	Business/Ind	dustry
Maryland 2	should be filed ind Mental Hygid is markad other umatic event, II	To Be Co	12th grade 17. Father's Name (First, Middle STINGREE MCA				TRAN	ISPUR	TATIC		r's Name	(First, Middle,	Maiden Suma	ите)	O STATE HOS
	1 and 2 Health a em 27 is ther tre		19a. Informant's Name/Relation Nina S. Ander 20a. Method of Disposition		ındaughţ	er 20b. Place	1538 o of Dispo	N.	STric	ker s	ST.,	Baltim	•	arylan	d 21217
Baltimore,	permit. Pages Department of I Important: If it any injury or o		12 Burial 2 Cremation 4 Donation 5 Other (Specify)	al from State		utus 22 W	Memo	nd Addres AM C	Park	y N COI	MUNITY	BALTIMO	DRE, M	IARYLAND
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0	ding Phys	ToB	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	Hospita 28a	l: 1 Inpatient . Date of Injury (Month, Day Ye		Outpatien b. Time of Injury		28c. Injury Work	r: 4□ Nui	rsing H <i>o</i> r	Check onl one 5 (Resident Resident Resi	lence 6 Ot		()
DIVISION	0 = 5 =	Certification;	3 Suicide 6 Could 4 Homicide detern	nined 289	. Place of Injury building, etc. (S	Specify)						City or Tow	m, State)		l Route Number,
1/	To the Hospitel within 24 hours a To the Funerel C completely filled	Medical	29b. Signature and title of certific	er Examiner: Or	To the best of men the basis of exidence of manner stated	amination	dge, death and/or inv	estigation	at the tim n, in my op c. License	inion, deat	d place, a h occurre	ed at the time, o	cause(s) and made and place	, and due to	the cause(s)
	1		30. Name and address of person	0	ed cause of death	h (Item 23	a) (Type,					auta			۲.
>	Sta Registr	45	31. Date filed (Month, Pay, Year								1 10		v ex w	1217	

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** JAN. BETTY A. McCOY 18 2004 12:00 PM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 105 POPLAR AVENUE GLEN BURNIE ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MARCH 9, 19 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗗 F 217-46-4080 56 1947 MARYLAND Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at MARYLAND ANNE ARUNDEL GLEN BURNIE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a 105 POPLAR AVENUE 21061 UNITED STATES Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "natural", or Ital any injury or other traumatic event, the Medical Evacution once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLEANER 12 CLEANING SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM HENRY MARSH BETTY ANN THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLEY M. LENIK - DAUGHTER 417 BALTIC AVENUE FERNDALE, MARYLAND 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JANUARY 21 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State MEADOWRIDGE MEM. PK. 2004 ELKRIDGE, MARYLAND 4 Donation (5 Other (Specify) 21. Signata e cl. Fun val Service Lioensee kîrkîtêw Awîbû'î cîw funeral Home P.A. 21061 421 CRAIN HIGHWAY S.E. GLEN BURNÎE, MARYLAND 3 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HETCORRHAGE **Physician** SUBARACH NOID /Medical Examiner PTURED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o detached 9 Unknown 9 Unknown Division of Vital Records, P. signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate ormea? 2 ☑ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation death. 1 Tes 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2 D0035781 De 11 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 10 TOHNS HOPEINS - MEYER 5.18/ RIGATIONTI, 170 DANKELE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2004 Registrar

		1 - For State Registrar	State of Maryland / D	epartment of He Certificate of De		ygiene Reg. No. 200	4 0109
Physic /Medi	cal	Decedent's Name (First, Middle, Last) Lorraine Janse 4a. Facility Name (If not institution, give s		4b. City, Town, or Lo	2. Date of D Month Januar	Day Year	0137 ^M
Examir Funeral Director	ner	Carroll Hospital 5. Social Security Number 6. Sex	Center 7. Age (In yrs. last birth	Westmin		Carroll Oay, Year) 9. B	irthplace (State or Foreign Country)
ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md Carrol1	10c. City, Town Sylcesv	ille			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ath with the 23s or 2	rat Dire	7512 Patapsco Driv	<i>r</i> e	10f. Zip Code 21784		10g. Citizen of What C	Country?
72 hours after death with the Maryland natural', or tems 23s or 28s-f show dical Examinations to notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	77	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	14. Race - Am Black, Wh Specify: Wh	nite, etc.
J within jiene r than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	Decedent's Usual Occupation (Give kind of work done dur life. DO NOT use retired) Waitress/hor	ing most of working	16b. Kind of Busines food servi	s/Industry ce/domestic
should be filed nd Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Elmer Jansen		_	3. Mother's Name (First, Middle Hazel Collins	le, Maiden Sumame)	
s 1 and 2 should f Health and Mer tem 27 le marke other traumatic		19a. Informant's Name/Relationship (Ty) Maureen F. Schehl	(daughter) 75	12 Patapsco I	d Number or Rural Route Num Dr., Sykesvill	e, Md 21784	
00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemetery	Disposition (Name of r, crematory or other place) unty Crematic	Date on 1-21-04	20c. Location - City of Sykesville	
permit. Pages Department of Important: If it any injury or onges.		21. Signature of Funeral Service License	Haidt	P.O. Box 10	o ^{r Facility} Haight Fu 95 Sykesville.	neral Home	& Chapel
Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Puero (or as a consequence of	ot enter the mode of dying, s	such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death Z WES
te be executed xx xicien and e buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Ir jury that initiated events resulting in death) Last	Due to (or as a consequence of CAROAC OSTIC	GENERATIVE L 10: ACTIVE FULLIO	Demontal		>2 YEARS > 10 YEARS
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law requires that the as been signed by the 2 should be detache	by	Part II. Other significent conditions con	tributing to death but not resulting in	the underlying cause given		tobacco use contribute Yes 2 ☐ No 3 ☐#	to the cause of death? robably 4 Unknown
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hysicial Ins certii	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	ospital: 1 Inpatient 2 ER/Outp	04	6. Place of Death (Check only 4 ☐ Nursing Home 5 ☐ Res		ecify)
ling I. After fune	Certification:	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		jury Work? M 1 ☐ Yes	s 2 □ No	how injury occurred	
To the Hospitel or Attending within 24 hours after death of To the Funeral Director; Alte completely filled in by the fune	Certifi	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		City or To	(Street and Number or F own, State)	
Fo the Hospitel or within 24 hours after Funeral Dir. completely filled in in	edicai	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, for investigation, in my opini	date and place, and due to the ion, death occurred at the time	e cause(s) and manner a , date and place, and du	is stated. e to the cause(s)
To the To the comp	Ň	29b. Signature and title of certifier		29c. License ni	umber 06	29d. Date signed (Mon	th, Day, Year)
V		30. Name and address of person who co	mpleted cause of death (Item 23a) (T	ype, Print) 1000 LIBURTY	ROAD FUNCO	1719 201 (BURG NY)	21784
Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0	32. Registrar's Signature	ser i	, ,		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	f Marylan		artment of F rtificate of		ana me		ene g. No. 2 (004	01096
			1. Decedent's Name (First, Middle, La	ast)					2	2. Date of Death		Vana	3. Time of Death
	Physici /Medio		Mattie Elizabe	th McKe	enzie				ر. ا	anuary	Dey 16.	Yeer 2004	12:04 PM
)	Examir		4a. Facility Name (If not institution, given				4b. City, Town, o	r Location o		arrace j		nty of Death	12,007
			1416 Rowe Drive				Glen Bur	nie			Ann	e Arun	ndel
	Funeral				7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8	Date of Birth (Month, Day, anuary	Vearl	9. Birthp	place (State or Foreign
	Director		215-28-9333	1□M 2 X 7F	70	Yrs.	Months Days	Hours	J.	anuary	25 ,19	33 Ma	ryland
	pu ,		Usual Residence of Decedent		140.00								•
	aryle hov	_	10a. State 10b. County		TOC. City	, Town or Lo	cation					יי	Od. Inside City Limits
	Ba-f	octo	Maryland Anne Ar	<u>undel</u>	Gl	Len Bur							1 ☐ Yes 2 No
	or 2	D E	10e. Street and Number				10f. Zip Code			10	g. Citizen o	of What Coun	ntry?
	within 72 hours after death with the Marylend ene. then "natural", or items 23e or 28a-1 ehow ta Medical Examinar must be notified at	Funeral Director	6670 Shelly Road				21061					State	
	er de	une	11. Marital Status	Armed For		S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Oriç an, Mexican	gin? (Specr ı, Puerto Ri	fy Yes or No- can, etc.)		lace - Americ lack, White,	
36	s aft	by F	1 Never Married 2 Married 3 Wildowed 4 Divorced	1 ☐ Yes If Yes, Giv	2 No		1 ☐ Yes 2 ☑ No	Specify:			Spec	cify: Whi	+-
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	Hyg Hyg other	Ö	17. Father's Name (First, Middle, Last			INL	ırse's Ai		r's Name (/	First, Middle, M	aiden Sum	sing H	lome
au	ld be ental ked o	To Be	Frank Driggers						Lore	tta His	koo		
Maryland	should be and Mental marked o	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Numbe				m. State. Zip	Code)
	od 2 lith a 27 is r trau		Ray McKenzie - so	n			et Court						
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, if a Medical Examinat must be notified at once.		20a. Method of Disposition		20b. Pl	lace of Dispos	sition (Name of	- 1	Dat			n - City or To	wn, State
Baltimore,	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Co	☐Removal from S	State		natory or other plac	,	201 2022	10, 2004	Till less i	د دهال	
₹	artmoorter		21. Signature of Funeral Service Lice		Mea	ICCWL IC	ge Cemet . Name and Addre	ss of Facility	V Lings	19,2004	ETKLI	Lage, P	Maryland The
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		-	For State Registrar	State of Maryland /		ent of Hea ate of De		Reg.	2001	01097	
	Physicia /Medic	an al	1. Decedent's Name (Fjrst, Middle, L PATRICIA M	ANNING				2. Date of Death Month	15, 2004	3. Time of Death 4,25 A M	
	Examin	er	4a. Facility Neme (If not institution, gl	ve street and number)	46. c	ty, Town, or Lo	CRT		4c. County of Dea	th	
4	Funeral Director		217-46-4844	7. Age (In yrs. last in 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	birthday) If Un Month		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye AUG. 27,	9. Bir 1949	Inplece (State or Foreign buntry) MD	
e, Maryland 21215-0036	iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland infraeriof Health and Mental Hygiene. Intract; or Items 23a or 28a-f show intant; if Item 27 is marked other than "natural", or Items 23a or 28a-f show jury or other traumatic event, if a Medical Examinal must be inclined at	To Be Completed by Funeral Director	10e. Street and Number 920 BETHUNE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced 15. Decedent's (Specify only highest generally/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last	ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Education rade completed) College (1-4or 5+) 0 10 College, Print) ANNING (DAUGHTER)	13. Was De If Yes, s 1 Yes 6a. Decedent's U (Give kind of life. DO NO SEA	Zip Code 21.2 cedent of Hisppecify Cuban, N 22 XNo S sual Occupation work done durit T use retired) MTRESS ess (Street and	MARY Number or Rura ROAD BA	ecify Yes or No-Rican, etc.) ing 16i (First, Middle, Mai MACK al Route Number, C	, City or Town, State, Zip Code)		
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Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manper of Death Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	(Month, Day Year)	b. Time of Injury M , farm, street, fac		s 2 🗆 No	28d. Describe how 28f. Location (Stree City or Town, S	et and Number or R	ural Route Number,	
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)	To t with or To t	Σ	29b. Signature and title of certifier MI Challe	Sulula	MD	29c. License n D 267	200	29d J <i>F</i>	Date signed (Mon	th, Day, Year) 16, Z04	
, á	10 st	ate	3. Name and address of person when the state of the state	d completed cause of death (Item 23 GUTUGA) D PT 32. Registrar's Signature	of 14	Holes	sy. HA	RBOR H	05P.		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrar	State of Mary		artment of H			ene 1. No. 2004	nings
	Physici		Decedent's Name (First, Middle, Last) Sophia Mary	Mirowski				2. Date of Death Month	Day Year 19, 2004	3. Time of Death 2:30 A M
	/Medio Examir		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Death	h
	Funeral Director		5. Social Security Number 6. Sex 122–18–2801	7. Age (Ir	7 yrs. last birthday)	Crofto II Under 1 Year Months Days		8. Date of Birth (Month, Day, Y May 19 1	Anne Arui (ear) 9. Birth (926 But	ndel hplace (State or Foreign untry) ffalo, NY
	e Maryland	Director	Usual Residence of Decedent		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	i Dire	10e. Street and Number 8331 Westside Driv	0		10f. Zip Code 21108		10g	USA	untry?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic svent, the Medical Examiner must be muitted at	by Funerai		12. Was Decedent Ever Armed Forces? 1 Yes 2 No Il Yes, Give Year or Dates:		Was Decedent of Hi I Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: White	e, etc.
Maryland 21215-0036	od within 72 hogiene. er then "netu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, memaker	luring most of work	ing 16	b. Kind of Business/I	•
ryland	should be filed of the standard Mental Hygie marked other umatic svent, It	To Be (17. Father's Name (First, Middle, Last) Leonard Swit				Ladis1		Mikstac	
altimore, Mar	. Pages 1 and 2 she iment of Health and lent: If itam 27 is m jury or other traums		19a. Informant's Name/Relationship (Ty) Jacqueline Roberts 20a. Method of Disposition 1 □ Burial 2√ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	on emoval from State	312 Ob. Place of Dispo	Larch Pla	ce Steve	enville, I Data 200	City or Town, State, Zing MD 21666 c. Location - City or Tevensvill	Fown, State
Ball	permit. Page Department of Importent: If any injury or once.		21. Signal 14 of Funer II Service License 23. Part1. Enter the disease, or compli	M01220	>		Funeral	Home PA (le, MD 21061
8760,	Physician /Medical Examiner sthe pnial-transit sthe pnial-transit	dical Examiner	shock, or heart fatilyte. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	msive insequence of): Sclenations of the contraction of the contractio			, ,	Sease istyse	Approximate Interval Between Onset and Death Jews Peus
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	10		30. Name and address of person who col	ARC	RA	MD 14	300 GA	ALLANT	FOXLN,	BOWI 15 MD26715
7	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's S	M A	0 a No 2				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Donald Palmer Moody Sr. 0200 January 19,2004 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Stella Maris at Mercy Hospital Baltimore If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠ M 2□ F 235 26 2850 Yrs. Director 83 23,1920 West Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 N. Meadow Drive 21060 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11 Marital Status Black, White, etc. Armed Porces r 1 TX Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 ia marked other than "n. Elementery/Secondary (0-12) College (1-4or 5+) Painter General Contractor 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Moody Ardenia Thompson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Haalth a Important: If item 27 is using any injury Donald Moody Jr. / son 117 N. Meadow Drive Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 1/20/04 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George J. Gonce Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician' Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner sician and burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial-Physician/Medical Due to (or as a consequence of) attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 V63 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert 5 Pending investigation 1 Matural hours after death. uneral Director: After the filled in by tha fun 1 TYes 2 TNo 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide spital or To the Hospital
within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 1912004 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 87

DHMH 16 Rev 6/95

State Registrar

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ada Wallett Miller January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tome 5. Social Security Number If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 03/04/1913 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, Funeral Months Hours 1 ☐ M 2 X F Maryland 90 Director 215-09-5191 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Director MD Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 USA 561 Pennington Avenue death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Real Estate Broker Self-Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phoebe Robinson Joseph C. Barnard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 561 Pennington Ave., Havre de Grace, MD 21078 Pamela Wallett- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 01/14/04 Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery Signature of Funeral Service Licensee Name and Address of Facility Wittchell-Smith Funeral Home, P.A. Washington, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 aVU **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dug to Examiner use as the burial-transit certificate be executed MM that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ö Month Day Year 4⊡Pregnant at time of death signed by the at id be detached for 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part h. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Willes Asa W 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 2 No 1 🗌 Yes ours after death.

neral Director: After this certifical filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗆 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04 D person who completed cause of death (Item 23a) (Type, Print) 0.7

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Beverly Mered:th 11:40 AM 01 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSDITAL Havre de Grace Hortord H artord Memorial County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Director 218-38-3147 61 07/06/1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Exeminar must be notified at 1X Yes 2 □ No Director MD Havre de Grace Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Alliance Street 21078 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: ģ Specify: White 3 ☐ Widowed 4 ▶ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental PImportant: If itam 27 is marked of any injury or other traumatic even d 2 should be f h and Mental I John R. Ledman Eva B. Poist 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric W. Taylor- Son 5042 Bristle Cone Cir., Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Harford Mem. Grdns. 01/12/04 Aberdeen, MD 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, laura MD 21078 (23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Physician involvic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ obe isity Morbid 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? maestine Heart this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2□No of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending To the Hospital or Attandia within 24 hours after death.
To tha Funaral Diractor: All completely filled in by the fu М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058904 MD 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drison Groce MD 319 Avenue

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 10 2004 January 3:55 P ™ E Matusz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Co. Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. January 11 1920 Baltimore City, Md 220 07 5975 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Harford Director Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 504 N. Paradise Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Waitress Restaurant d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frank Dull Irene Ehrhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 is any injury or other trau once. Doris L. Kick 35 Rader Court Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. January 14 2004 Baltimore, Maryland 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Schemic mon this Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 POutpatient 3 ☐ DOA 1 Yes 2 No Division of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1/X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò To the Hospital within 24 hours a To the Funerel C 1/X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier D0056607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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32. Register's Signature

South Afwood

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			Certificate of Death		Reg. No. 200	4 01103
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Ye	3. Time of Death
4.	/Medic		ERMA K. MARSHALL	January	7 13, 200	04 11:10 AM
	Examin	er	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo			
			1 Village Drive - Apartment 1 Crisfield 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		1	Merset
	Funeral Director		214-02-8925 1□M 2反射 71 Yrs. Months Days Hours Min.	8. Date of Birtl (Month, Day July 11		Birthplace (State or Foreign Country) Maryland
	puel *	1	10a. State 10b. County . 10c. City, Town or Location			10d. Inside City Limits
	Man	ţ	Maryland Somerset Crisfield			1/□XYes 2 □ No
	or 28	Funeral Director	10e. Street end Number 10f. Zip Code		10g. Citizen of Wha	t Country?
	23.	rai	1 Village Drive - Apartment 1 21817			SA
	tems tems	nue	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
21215-0020	filed within 72 hours after death with the Marylend Hygiane. ther than "natural", or flems 23e or 28e-f ehow ent, the Medical Examinet must be notified at	Completed by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2万No If Yes, Give 1 ☐ Yes 2 ☐ Y	-	Specify:	White
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an	る 草 草 🍷	o Be	Richard T. Smith Clara E	•	,	
Maryland	는 DEF	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	ai Route Numbe	r, City or Town, Sta	te, Zip Code)
ž	od 2 27 is	ĺ	Katie Schoffstall (Dau hter) 106 Columbia Avenue -	Crisfie	eld, Marv	land 21817
J.e.	as 1 en of Heel Itam 2	1	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City	
Ē	Page nant: If ury of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park 1/	/16/04	Crisfield	d, Maryland
Baltimore,	permit. Pagas 1 Depertment of H Important: If Ital any Injury or ott		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradshaw & Sons Fun	neral Ho	ome	***************************************
ш	205 2		Mary Beth Bradshaw-Pruitt 306 W. Main Street	- Crisf	ield, Man	cyland 21817
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	or respiratory are	rest,	Approximate Interval Between
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) A S C V D			
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/	uted d ansit	Examiner	b. Due to (or as a consequence of):			
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P.O.	the de	ysi	Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I.		\	oute to the cause of death?
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Vital Records,	requires that the de been signed by the should be datached	돃		24a. Was a		4b. Were autopsy findings available prior to
ပ္သ	s bee 2 sho	Completed		perfor	ined:	completion of cause of death?
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ta		Be	25. Was case referred to medical examiner?	(Check only or	ne)	
-	S S	ို	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor		ence 6 Other (Specify)
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isic	Attending or deeth. octor: After by the fune	cat	3 Suicide 6 Could not be 200 Bloom of Injury. At home, form, street, featons office.	28f. Location /S	treet and Number o	r Rurei Route Number,
Division	after after Direct Dire	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Tow		
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After the complataly filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a			
	he Hç iin 24 he Fu platal	edical	(Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurre and manner stated.			
	Vith Tot	Σ	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (M	lonth, Day, Year)
	1		D48098		January :	L5, 2004
	V		30. Name end address of person who completed cause of death (Item 23e) (Type, Print)	c' 1	, , , ,	21017
			Vijay Karumbunathan, M.D. – 201 Hall Highway – Crisf 31. Date filed (Month, Day, Year) 32. Register's Signature	tield, M	maryland 2	7181 /
Ĭ.	Sta Registra		31. Date filed (Month, Day, Year) 7 200 4 32. Regintrer's Signature			

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MURPHY JAN 2004 BEATRICE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner BALTIMORE GENESIS LONG GrEEN 115 E. MELROSE AVE If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 □ M 2 ☑ F **Funeral** Months Deys 213-64-7279 July 14 1927 Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mantel Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be not fed at 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 Yes 2 No BAITIMORE MD Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21212 U.S.A 115 E. MELROSE AVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: BIACK <u>ک</u> 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Service COOK 100D 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Be MUR PHY MARY MURPHY James 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PARK AVE. Md. COMM. ON Aging-Ms. Lucas BAITO MD, 21201 515 Important: if item any injury or other page. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 □ Cremation 3 □ Removal from State BAItO, MD 1-19-04 MT. CARMEL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Michael Ziglier Fyn. Svc., P.A.
P.O. 67338 BAITO, MD, 21215 21. Signature of Funeral Service Licensee alier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical MONTHS Elaminer Physician/Medical Examiner ettending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events ementis Division of Vital Records, P.O. Box 68760, resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the e should be datached 1 Yes 2 No 3 Probably 4 Unknown HUPERTENSION Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? DEGENERATIVE JOINT DISPART 2 X No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 9 To the Funerei Director: After this completely filled in by the funeral di 28c. Injury at Work? 27. Menner of Death 28e. Dete of Injury (Month. Dev Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Neturel 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier To the To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) JANUARY M. O D0058457 2004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) N. EUTAW ST, STE 308, BATTIMORE MD 21201 NANA CEASAR M.D.; 821

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrar's Signature

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			For	State of Marylar	•			ental Hygi	ene 2001.	01105
		•	- State Registrar		Ce.	rtificate of I	Death	Re	g. No.	Ulluj
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	/Medic		4a. Fecility Name (If not institution, g		- / - 1		Location of Death	3 111101110	4c. County of Deal	
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	and *	}	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
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	ith t	Director	10e. Street and Number	LD RD		10f. Zip Code	1224	10		_
	tied within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-f ehow ent, the Medical Examiner must be notified at	Funerai	6917 HARFOR				1234		U.S.	
	ems erra	Ine	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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Maryland 21215-0036	should and Men a marke umatic	8	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)
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ည်	一主革章		20a. Method of Disposition	20b.	Place of Dispe	osition (Name of	, D		Oc. Location - City or	Town, State
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			23a. Pa 11. Enter the disease, or co shick, or heart failure. List on	mplications that caused the dea ly one cause on each line.	ith. Do not en	ter the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
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760,	be e icier buris	calE								
87	cate phys	dic	,	d						
Box 68	ding se as	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy.				224 8-1-44	
30	ath c ttend or us	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	tal death 3	Ectopic pregnancy	1		23d. Date of de Month	Day Year
-	he a	sic	1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				
P.0	w requires that the death certificat been signed by the attending phy should be detached for use as th	Completed by Physician/Medi	9 Unknown					00- Dida-b		who are at death?
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⋚	ysician: is certific director.	Be	25. Was case referred to medical examiner?	Hospital:	Dénie .	ot 3 DOA Oth	26. Place of Death			-
o	Phys this al di	2	1 ☐ Yes 2 ☑ Ño 27. Manner of Death	1 Inpatient 2	⊇ER/Outpatie 28b. Time d	11 3D DOX	4 Hursing Ho		nce 6 Other (Spe w injury occurred	city)
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<u>s</u>	eath or: /	cat	2 Accident investigat 3 Suicide 6 Could not	t he			Yes 2 □No			
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	Hospitel or Attending Physician: The law requires that the death certificate be executed at hours after death. Funerel Director: After this certificate has been signed by the attending physicien and teller filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Ce					J.			
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	To the l within 2. To the I	Ž	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
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-			30. Name and address of person wh		em 23a) (Type	Print)				
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			Tor State Registrar	State of Marylan		ment of H			giene 20	04 01106
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		RUBY R.	NE	WPORT			Jarkuar	Day 24/5 7	Year 10:39A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4	b. City, Town, or	Location of Death		4c. County	of Death
			The Johns Hop	Kins Hospi	Fac 1	Saffi	nene C	ity		NIA
	Funeral		5. Social Security Number 6. Sex	7. Age (fg/yrs. M 252 F 74	last birthday) N	f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 8 - 22 - 1	h v. Year)	Birthplace (State or Foreign Country)
	Director		212-26-4694 Usual Residence of Decedent	X- /-I	115.			8-22-1	929	Maryland
	land ow	1	10a. State 10b. County		y, Town or Locat	ion				10d. Inside City Limits
	Mary Ind	to	MD n/a	a B	altimo	re				1. Yes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?
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fis.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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Box	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 mg/hths?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 □Ed	topic pregnancy			23d. Date Mor	e of delivery hth Day Year
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rds	quires n sign	d by	STROKE					1 🗆 Y	res 2□No	3 Probably 4 Onknown
Records,	w requir	olete	NVOCAR	NAL INF	LPC TI	(DN)		24a. Was	an 24b. V	Vere autopsy findings available
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Viital		a	25. Was case referred to medical				26. Place of Deat			2010
>	S D	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Resid	dence 6 □Othe	er (Specify)
Division of			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	now injury occurr	ed
Ö	Attanding r death. actor: Afte by the fune	atle	2 Accident investigation		. ,	M 1 🗆 🕆	Yes 2 □ No			
Ž	I or Attandii after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street y)	, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
٥	ital o									
	To the Hospital or Attantwithin 24 hours after deatl To the Funaral Director: completely filled in by the	edicai	29a. Certifier 1 Cartifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death o tion and/or inves	ccurred at the tim stigation, in my op	ne, date and place, pinion, death occur	and due to the ored at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
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)	F ≯ F 8		> nieles.	Manela	L, MD	0	ES-006	0 .	TANILA	24 15,2004
	\		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Tvne. Pri				O FAILU C PAIN	-,,
	1					•	FE STRE	ET, BAL	TIMORE	, MD 21287
*	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa						
	Registr	ar	MONTH OF THE PORT	March Land	T An	Rokal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

				For State of Maryland / Department of Health and I - State State Certificate of Death Certificate of Death	Mental Hygie	ne 2 0 0 4	01107
				Registrar 1. Decedent's Name (First, Middle, Last)	Reg.	. No.	3. Time of Death
		Physici		Kenneth Eugene Norton, Sr.	Janua	Day 14 200	
		/Medio Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4e. County of Deat	
				Upper Chesapeake Medical Center Bel Air		Harford	<u>E</u>
		Funeral		5. Social Security Number 219–28–5038 6. Sex 1 \(\mathbb{R}\mathbb{M}\) 2 \(\mathbb{L}\mathbb{F}\) 7. Age (In yrs. last birthday) 1 \(\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\mathbb{M}\) 2 \(\mathbb{L}\mathbb{F}\) 72 Yrs. 1 \(\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\mathbb{M}\mathbb{M}\mathbb{M}\mathbb{M}\) 1 \(\mathbb{M}\	(Month Day Y	9. Birth	nplace (State or Foreign untry)
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		e Mar	cto	Maryland Harford Abingdon			1 ☐ Yes 2X No
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	36	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: Bl	ack
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16	Baltimore,	permit. Departn Importa any inju		21. Signature of Imeral Service Licensee 22. Name and Address of Facility McComas Funeral Ho			
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+ l	X	_ 0, 10		IF FEMALE: 23c. If yes, outcome of pregnancy			
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26	P.O.	the d by the ached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
ENNE		w requires that the death cer been signed by the attendin should be detached for use	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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义	ecc		Completed	Consiste Heart Failur	24a, Was an autopsy	24b. Were aut	opsy findings available
>	œ.	The law are has be page 2 st	Con		performed 1 ☐ Yes 2	death?	
VO.	Vita	ilcian: The lar certificate has rector, page 2	Be	examiner? Hospital:	th (Check only one)		
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\geq	Division of Vital Records,	al or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rur	al Route Number,
	Ö	italor rsafte ralDir ledin	Cert				
	2	To the Höspital or Attending Physician: The la within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
_		To the l within 2 To the l complet	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	
	•	21/		Myllocal MD V3065	3	1-15	-04
	1	(H)		30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)	1#3	06 D	1 A
		(O)		Roser E Schwider -520 Uppe Chese; 31. Date files (Month 2004) 32. Registrar's Signature	regge Ki	Tre, De	litin
		Sta Registr		JAN 2 0 2004 Perers			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 01108 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NETLSON Day **Physician** Month Yeer 2004 09:18 AM IRGINIA January /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth center Baltimore Hospital Harbor 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🌠 F Days Hours 213 24 6603 73 Director Feb. 24, 1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director Anne Arundel 1 ☐ Yes 21 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 420 Holy Cross Road 21225 U.S.A. Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2X No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress McDonald's 10th is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental Ben Williams Anna Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 :
Department of Health ar
Important: If item 27 is
eny injury or other treu William Neilson / son 420 Holy Cross Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/22/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George J. Gonce Funeral Home, P.A. Reme memurall 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Rart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** 02 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Day 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed COPO 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed 1 ☐ Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Matural 5 Pending within 24 hours after death. To the Funers! Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES eyssa 000 (emma January HARBOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL Baltimore EYOB MA Feyssia 3001 S

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Hanover S s Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** anuavii 59 SUSA VOL 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1 movt ISTOWY If Under 1 Year | If Under 24 Hrs. Birthpfece (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 219-05-1769 Feb. 1920 83 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 XNo Baltimore Maryland Baltimore Funeral Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1104 Landington Avenue 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White A 3 Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Fabricator Sheet Metal Mfg. 12 Years other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental h Joseph Howard Ogle Myrtle M. Roe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itsm 27 is any injury or other tra once. 1420 Thistlewood Drive, De Soto, Texas 75115 Joanne M. Craven, Daughter 20a. Method of Disposition

14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Crest Lawn Mem. Gardens 01/19/2004 Marriottsville, MD * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 630 Edmondson Ave., Catonsville Witzke Funeral Home of Catonsville, Inc.MD 21228 P. Steven Danfelt, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 1 Yes 2FNo funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3/ ER/Outpatient 1 🗌 Yes 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0052760 30. Name and address of person Old COURT 5401 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.	0110
Physician		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death 8:00 pm M
/Medical Examiner	-	Robert Francis Provenzano 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
ineral rector		Gilchrist Center for Hospice 5. Social Security Number 213-34-4062 Gilchrist Center for Hospice Towson Baltimore Towson Funder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/14/1938 9. Birthplic Country Number 4/14/1938 9. Birthplic Country Number 4/14/1938 1/2	ace (Stete or Foreign
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	0d. Inside City Limits 1 ☐ Yes 2 X No
Director	Lecto	Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Count	
ust th	a	713 Riverside Drive 21221 U. S. A.	an Indian
hy Firmeral	2	3 Widowed 4 Divorced Year or Dates: Whi:	etc.
Completed	ublered	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ind	lustry
a 2	5	12 Master Electrician Utility 17. Father's Name (First, Middle, Last) Master Electrician Utility 18. Mother's Name (First, Middle, Maiden Sumame)	
To Be	0	1	
aume	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	
one injury or other traumetic event, the Medical Examinar must be notified at once. To Be Completed by Finneral Director		Valeria Provenzano (Wife) 713 Riverside Drive Essex, Maryland 2122 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Cardens of Faith Cem. 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Cardens of Faith Cem. 20c. Location - City or Town 1/23 20d. Baltimore, Maryland 2122 20d. Location - City or Town 2/20 20d. Baltimore, Maryland 2122	wn, State
eny injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Partition of Funeral Home PA 1407 Old Eastern Avenue Essex, Marylai	
sician edical miner	9	Immediate Cause (Final disease or condition resulting in death) a. Cell Chncer Due to (or as a consequence of):	Approximate Interval Between Onset and Death Warning W
na eu	dical Examiner	d	
detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ry Day Year
should be deta	ed by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I. 1 Yes 2 No 3 Proba	e cause of death? ably 4 □Unknown
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E CO	Σ		
7-11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1) A - 12 Ley C-BMC 6701 N. Charles St. Balto. Md 2 (2)	ox
State Registra		31. Date filed (Month, Day, Year) 32. Register's Signature	

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		•	For State Registrar		•		rtificate of			Reg. N	- 7111	0111
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Phys /Me	sicia edica		Melvin Joseph	Pijanowsk	i				Januar	ry 1	6 , 200	4 8:00 a ™
Exa			4a. Facility Name (If not institution, give Stella Maris	e street and numbe	r)		4b. City, Town, o Dulaney	Valley	ר		c.County of D Baltim	
Funer Direct			213-03-6670	ex 7. A ☑M 2□F	lge (In yrs. I. 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D March	irth ay, Yea 1,19.	9. 20 M	Birthplace (State or Foreig Country) aryland
land ow		}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
Mary -f sho		ţō	Maryland Baltimor	Έ	Mide	dle Ri	ver					1 ☐ Yes 2 ☒ No
h the		rec	10e. Street and Number		1 2224	-10 111	10f. Zip Code			10g. C	itizen of Wha	t Country?
th wit		<u>a</u>	200 Kingston Road				21220			U.S	S.A.	
r dea		Funeral Director	11. Marital Status	12. Was Deceder Armed Forces	3?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-		American Indian, Vhite, etc.
s afte		by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1) (Nes 2) If Yes, Give Year or Dates	10	44-	1 ☐ Yes 2XXXIo	Specify:			Specify:	White
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Demili Pages 1 a Department of Hes mportant: If item any injury or othe	5		20a. Method of Disposition 12☐Burial 2 ☐Cremation 3 ☐				esition (Name of matory or other place					or Town, State e, Maryland
permit. Pages Department of Important: If it			*4 □ Donation 5 □ Other (Specifical Service Licer	_	LIOT		_		•	1		
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-9-			23a. Party. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death	. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory	arrest,	SCA, PR	Approximate Interval Between
Physicia /Medic Examin	eal	ıer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	Due to (or a	IMER'S	ience of):	ASE					Onset and Death
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law requires that the as been signed by th 2 should be detached		by Pr	Part II. Other significant conditions of	ontributing to death	but not resu	Ilting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribu	te to the cause of death?
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To the within To the		Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (M	onth, Day, Year)
all	1			12			DY	3725			1/16	104
iUT	3		30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)				/	
			DR. TARIQ MAHMOO				LEY RD.	TIMONIUM	MD 210	093_		
D	Stat	e	31. Date filed (Month, Day, Year)	2004 32. Red	trar's Signat	ure	(carle)					

04-0033 DAP	ر 1	For UNPEND ITEM 23a, 276 288 - 9 Maryland 27	Depa Cei	ertmen rtificate	of H	ealth a Death	ind M	lental Hyg	iene 2 (04	0 !	
		Negistrar 1. Decedent's Name (First, Middle, Last)						2. Date of Deat	h Dav	Veer	3. Time	
Physicia	n	KEVIN A PARKER						jandary	13,200)4	8:35	ам
/Medic Examin	_	4a. Fecility Name (If not institution, give street and number)		4b. City.	Town, or	Location o	of Death		4c. Count		1	
LAdmin		HARBOR HOSPITAL CENTER		BAL	CMLT	RE CI				A/P		
Funeral Director		5. Social Security Number 6. Sex 213-02-6225 6. Sex XXM 2□ F 7. Age (In yrs. last to the security Number) 36	virthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day) June 21	Year) 1967	Cou	ptace (State untry) RYLAN	
D	}-	Usual Residence of Decedent	um or Le	eation							10d. Inside	City Limits
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Ba-f o	5	MARYLAND N/A	TIM	ORE 10f. Zip	Code			1	Og. Citizen of	What Co	untry?	
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23	rai	901 CHERRY HILL RD APT 158	13		2122 dent of H		igin? (Sp	ecify Yes or No-		ce - Amei	ncan Indian,	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. It was a second term and the marked other than "naturel", or Items 23e or 28s-f show other traumatic event, the Madical Examinar must be notified at	ᆵ	11. Maritaf Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give	i	If Yes, spec		Specify:		ecity Yes or No- Rican, etc.)		ack, White ify: BIJ		
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permit. Pages 1 ar Department of Hes Important: If Item any Injury or othe once.		21. Signatural Fineral Service Licensee		LLIAN L206 V				MUNITY F	UNERAL	HOM	E P.A.	
Physician /Medical		23a. Pert 1. Enter the disease, or complications that caused the death. It shock, or heart faifure. List only one cause on each line. If mmediate Cause (Final disease or condition resulting in death) AMTRIPIYIAN Due to (or as a consequent or consequent or condition resulting in death)	E IND			ng, such as	cardiac	or respiratory ar	rest,		Approxin Interval I Onset ar	ate Between ad Death
Ifficate be executed with a physician and as the burial-fransit	dicai Examiner	Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulfing in death) Last b. Due to (or as a consequent or as a consequent of the consequent of th										
ne death cer the attendin	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	□Ectopic p		у				Date of de Month	livery Day	Year
ires that the signed by		Part II. Dther significant conditions confributing to death but not resulting	ig in the	underlying	cause gi	ven in Part	l.		obacco use co res 2 🗆 No			of death? Unknow
OIVISION OF VITAL DECOLDS, to Attending Physician. The law requires taller death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was autor perfo		b. Were an prior to death?	utopsy findir completion 2 No	igs available of cause of
iclan: Th	Be	25. Was case referred to medical examiner?					e of Dea	ath (Check only o	ne)			
Physiclan: This certific al director,	10	1 ☐ Yes 2 ☐ No ☐ No ☐ I ☐ Inpatient 2 ☐ EP		ent 3 🗆 E	X)A		lursing H	lome 5 Resid			ecify)	
Attending Physiclen: r death. ector: After this certifics by the funeral director,		27. Manner of Death 1 Nafural 5 Pending (Month, Day Year) 2 Accident investigation 2 Accident	b. Time Unic lury 8:00:		28c. Inju Wo 1 [No	28d. Describe		Derruc		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide 6XXCould not be determined 28e. Place of Injury - At home building, etc. (Specify) FOUND AT	, farm,	street, facto	ory, office			28f. Location (901 CHERR BRO	Street and Nu Y HELL I OKLYN M	ROAD A	ural Route l PT#7	Vumber,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and manner stated.	ah anh	ath occurre	d at the ton, in my	ime, date a opinion, de	and place eath occu	e, and due to the urred at the time,	cause(s) and date and plac	manner a e, and du	s stated. e to the cau	se(s)
To the within ? To the comple	Mec	29b. Signature and title of certifier Rale Mass A.			9c. Licen	se number E			29d. Date sig JANUAR		th, Day, Yea , 2004	ur)
		30. Name and address of person who completed cause of death (Item 2	1	e, Print)	nn S	treet	, Ba	altimore	, Mary	land	21201	
St Regis	ate trar	31. Date filed (Month, Day, Year) JAN 2 0 2004	0	5	light	meks						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryla	-		t of Hea e <i>of De</i>			giene2 () (Reg. No.	- Control of the Cont	0
П	Physici	an	Decedent's Name (First, Middle, Last) GRACE MARY PERKIN						2. Date of De. Month JAN.		Year 1	3. Time of Death 1:15A M
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City,	Town, or Loc	ation of Deat		4c. County of		I.IJA
	Lxaiiii	CI	Anne Arundel Medi			Ann	apolis	3		Anne	Arun	del
	Funeral Director		213-10-7301	7. Age (in yr 1 76	s. last birthday) Yrs.	If Under Months		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, De May 19	h y, Year) ,1927		lace (State or Foreign try) LTUCKY
	Maryland a-f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Anne Arur		City, Town or Lo		undel	County			11	0d. Inside City Limits 1 ☐ Yes 2 XNo
	h with the 23a or 28a	Funeral Director	10e. Street and Number 835 Locust Drive	·		10f. Zip	^{Code} 20778			10g. Citizen of W USA	hal Coun	try?
9036	be filed within 72 hours after death with the Maryland stat Hygiene. od other than "natural", or Itema 23a or 28a-f show avent, the Medical Examination into India at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deced If Yes, spec		nic Origin? (S exican, Puert pecify:	pecify Yes or No o Rican, etc.)		- America White, o	etc.
1215-0	within 72 h ene. than "natu tin wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us SeWife		g most of wor		16b. Kind of Bus		-Own Home
Maryland 21215-0036	d be filed v enta! Hygie ced other t c avent, th	Be	12 yrs. 17. Father's Name (First, Middle, Last) Robert Bailey	N/A	11000	SCWIIC	18.			Maiden Sumame	·	
Mary	s 1 and 2 should by I Health and Menta item 27 is marked other traumatic a	10	19a. Informant's Name/Relationship (Ty) Steven Baxter (Gr				(Street and I	Vumber or Ru	ral Route Numbe	or, City or Town, S Md. 2177		Code)
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cree tro Cre	matory or of	ther place)	1-1	Date D~04	20c. Location - C		
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Pineral Service License	Plassel	22			heral i		e. Md. 2		
8760,	Physician /Medical Examiner physicien and physicien and physicien physicien and physicien and physicien are physician at the physician are ph	Ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	aquence of):	hn 014	e of dying, su	ch as cardiac	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
.O. Box 6	death certific e attending p ed for use as 1	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 /nonths? 1 □ Yes 2 △ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	ta≀death 3[∃Ectopic pre				23d. Date Mont		ry Day Year
<u>α</u>	es ign be	by	Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	nderlying ca	ause given in	Part I.		obacco use contrib es 2 No 3		e cause of death?
al Records,	The law ate has b page 2 s	Completed							24a. Was autop perfor 1 □ Yes	sy pr med2 de	ior to com ath?	osy findings available apletion of cause of 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	lospital: 1 papatient 2	☐ ER/Outpatier	nt 3□ DO	Other		th (Check only o		(Casal	
ion of	ding h. After fune	-	27. Mann→ of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?			ence 6 Other)
Division	- = E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory	, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural	Route Number,
	To the Hospital of within 24 hours after the Funeral Doubletely filled in	Medical ((Check only 2 Medical Examir one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred a vestigation,	at the time, di	ate and place n, death occu	, and due to the orred at the time, o	cause(s) and man date and place, ar	ner as stand due to	ated. the cause(s)
	To t To t	2	29b. Signature and title of certifier	water n	מר	290	License nur	hber 445	:	29d. Date signed	Month, C	Day, Year)
			30. Name address of person who co	mpleted cause of death (It	am 2 (Typ⊦,	Print)	A		Anna		n,	
	Sta Registi		31. Date filed (Month, Day Year)	32. Registrar's Sig	hature	Se I	,				<i></i>	

amend item#23a,PER ME,G833,7/8/04eg Robert A. Piper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-0477 State of Maryland / Department of Health and Mental Hygiene

1 - For Unpend Item#23a,27, Per ME,6829,3/22/0468
RegistrarAMFND ITEM #7 PFR FH C830 4/19/04 JH Printincate of Death

1. Decedent's Name (First Middle Last)
Reg. No. **AKG** 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Robert Allen Piper 17, January 2004 8:13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5440 Irvin Ruby Road Sykesville Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 → M 2 □ F 218-61-7527 **Director** Aug 31, 2001 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or itams 23a or 28a-f ehow event, the Medical Exarcher must be notified at 1 ☐ Yes 2 ☐ No Hampstead Director Carrol1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1615 Fairmount Road USA 21074 Pages 1 and 2 should be tiled within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "natural", or Itams 23. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes Give X 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes. Give 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene I other than Elementary/Secondary (0-12) College (1-4or 5+) None $\mathbf{0}$ None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Justin G. Piper Dana M. Alt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. & Mrs. Justin Piper (Parents) 1615 Fairmount Road Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 1/21/04 Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HATCHT FUNERALLYHOME & CHAPEL, PA (Box 195) 0 Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Disseminated Encephalomyelitis **Lcukodystrophy** Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an 1 Yes 2 No of Death (Check only one)

Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
Part II. Dther significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.
25. Was case referred to medical examiner?		26. Place o
1 X Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nurs
27. Manner of Death 1 Natural 5 Pending 2 Accident investigati		ime of 28c. Injury at jury Mork? M 1 Yes 2 N
3 Suicide 6 Could not		m, street, factory, office

sing Home 5 \square Residence 6430ther (Specify) At scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

	building, etc. (Specify)		City of Town, State)	
2 Medical Examiner: 0			, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s	s)
title of partifier	-1	29c. License number	29d. Date signed (Month, Day, Year)	

O.C.M.E. January 18, 2004

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

Mil 31. Date filed (Month, 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

after death.

within 24 hours a

To the

in by

Medical

(Check only one)

29b. Signature and title of pertifier

	1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygie	ne 004 0111
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last, Pauline 4a. Facility Name (If not institution, give Buy view Med	street and number)	4b. City, Town, or Location of Dea Baltinore	January	Day Year 4:00 A 4c. County of Death
Funeral Director	5. Social Security Number 6. Set 211-12-8899	7. Age (In yrs. last birthda M 2CXF 84 Yrs.	Months Davs Hours Mir	(Month, Day, Ye	9. Birthplace (State or For Country) 9. Birthplace (State or For Country) PENNSYLV
r death with the Maryland ema 23a or 28a-f ahow ar must be routlied at ineral Director	10a. State 10b. County MD N/A 10e. Street and Number		IMORE 10f. Zip Code	10g.	10d. inside City Li 1X) Yes 2[Citizen of What Country?
	3516 NOBLE STR 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		21224 3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes ★★★No Specify:	Specify Yes or No- rto Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE
e filed within 72 hours al Hygiene. I other than "natureit, vent, the Medical Exe vent, the Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wi DO NOT use retired) OK BINDER	orking 16b	PRINTING
s 1 and 2 should be filed within 72 hours efter f Heelth and Mental Hygiene. Itam 27 is marked other than "natural", or its other traumatic avent, the Medical Examination of the To Be Completed by Fu	17. Father's Name (First, Middle, Last) JOSEPH MEDEN 19a. Informant's Name/Relationship (Ty		den Sumame) NKNOWN		
Pages 1 and 2 si nent of Heelth and int: If itam 27 ie r iry or other traur	FREDERICK PITZ/ 20a. Method of Disposition 1 Denation 5 Other (Specify)	HUSBAND 351 emoval from State 20b. Place of Discemetery, Communication State 20b. Place of Discemetery, Communication State 20b. Place of Discementery, Communication State 20b. Place of Discementary, Communication State 20b. Place 20b.	illing Address (Street and Number or F NOBLE STREET, position (Name of rematory or other place) S OF FAITH 1/21	BALTIMORI Date 200	
permit. Pages 1 Department of H. Importent: if ital any injury or ott	21. Signature of Funeral Service Licens	A Chieff	22 Name and Address of Facility LTLLY & ZEILER 700 S. CONKLING	INC. FUNI	ERAL HOME BALTIMORE, MD. 2
ate be executed ysiclen end burial-trensit he burial-trensit lcal Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	11 1 - 1	arrhythmia		Approximate Interval Batweer Onset and Deat Eight hour
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quires thet an signed by uld be dete	Part II. Other significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.		to use contribute to the cause of death
The lar				24a. Was an autopsy performed 1 Yes 2	
g Phyelclen: er this certific erel director, n; To Be (27. Manner of Death	ospital: 1 Mnpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing of 28c. Injury at	ath (Check only one) Home 5 Residence 28d. Describe how in	
To the Hospitel or Attending Physical Within 24 hours after death. To the Funerel Director: After this completely filled in by the funerel di	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 Tes 2 No	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
thin 24 hours thin 24 hours the Funere mpletely fille	29a. Certifier 15 Certifying Physics (Check only one) 2 Medical Examination	ician: To the best of my knowledge, de ier: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To t within To t com,		พอ	29c. License number RES - 00	-	Date signed (Month, Day, Year)
State Registrar	30. Name and address of person who co	2) Tower 110, Doctory		oife St.; Bal-	timore, Maryand 21

		1	1 = For State Registrar	State of	Marylan		artmen rtificat			nd Menta		ne No. 201		01116
	Physici	an	Decedent's Name (First, Middle, Last Norfa	Cheris		Pretty	man				te of Death onth Uary	fê , 200		3. Time of Death 6:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give Genesis Cromwell	street and numb			4b. City,		Location of D			4c. County of Balti	Deeth	
34.	Funeral Director		5. Social Security Number 6. Se 212-56-3322	x 7	. Age (In yrs. i	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. 8. Date (Mc)	te of Birth onth, Day, Yo 7 18,1	949	9. Birthplac Country Vir	e (State or Foreign ginia
	Maryland -f e-how	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/Z	1		y, Town or Lo	ocation	E	Baltimo	ore Cit			10d	Inside City Limits Yes 2 No
	with the	Direc	10e. Street and Number				10f. Zip	Code	21:	218	10g	. Citizen of Wh		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie merked other then "natural; or Items 23a or 28a-f ehow other traumatic event, the Mudical Examerational for notified at	by Funeral Director	331 East 29th S1 11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? !⊠No	1	Was Dece If Yes, spe			n? (Specify Ye Puerto Rican,	etc.)	14. Race	- American White, etc	Indian,
Maryland 21215-0036	vithin 72 hounde. ne. hen "natural	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4	4or 5+)	life.	dent's Usu kind of wo DO NOT u	ork done d se retired	<i>luring</i> most o)	of working	16	b. Kind of Busi		
land 2	uid be filed within Mental Hygiene. rked other then * tic event, the Ma	To Be Co	17. Father's Name (First, Middle, Last) Clayton McAlli	2 Yea	ırs	ļ <u>.</u>	egai	AIGE	18. Mother's	s Name (First, orfa Sh		iden Surname,		u110 ₁
, Mary	and 2 should be alth and Mental 127 ie marked er traumatic ev		19a. Informant's Name/Relationship (7 Mr. William D. Pro		(Husba		ng Addres	s <i>(Street a</i> East	29th	Street	Balt		Mary	land 21218
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation Cher (Specify 21. Signification of Cherical Control C				serv.	ice (Date 1/19/20	004	c. Location - C Towson Maryla	, Mar	yland
Bal	Depar Impo any in		* July.	fal.	1//	ŀ	Duda-	Ruck	Funer	ral Hom	ne of	Dunda1k	792	2 Wise Ave
8760,	Physician and hysician and hysician and hysician and hysician and hysician signature.	ical Examiner	23a. Pert1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	or as a consequent as a conseq	Juence of): MULL uence of):	al.	4	ine					iterval Between Inset and Death ACCUT
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		th 2 ☐ Feta ant at time of d	I death 3	⊒Ectopic r ⊒ Other (s					23d. Date Mont	of delivery	y ay Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to de	ath but not res	culting in the u	underlying	cause giv	en in Part I.	2:			bute to the	cause of death?
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Vital	ysicien: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 □ Ir	patient 2] ER/Outpatie	ent 3□ D	OA Oth	\/	of Death (Che		ce 6 □Other	r (Specify)	-
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Division	tai or Attend rs after death el Director: ed in by the f	Certification;	3 Suicide 6 Could not b	286. Place	of Injury - At h ig, etc. (Speci		treet, facto	ry, office			ecation (Stre ity or Town,	et and Numbe State)	r or Rural I	Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direction Completely filled in bit	Medical	29a. Certifier TV Certifying Ph (Check only one) 2 Medical Example		sis of examina		nvestigatio	n, in my o	pinion, death		he time, date	e and place, ar	nd due to t	he cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Kum	indo		J		FT/F			I. Date signed		-
	10		30. Name and address of person who	VDO 56	014064	RAVEN		DE	ALTM	ORE n	202	1239		
	St	ate	31. Date filed (Month, Day, Year)	04 3a A	egistrar's Sign	ature	recei.	7						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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an	•								Month Januar	Z 5. 2	004	2:50
al	4a. Fecility Name (h A Par		ımber)		4b. City, Town, o	or Location	ol Death	Caraci	-	unty of Deet	
er			clay Str			Baltimor	e				NA	
	5. Social Security N		S. Sex		rs. last birthday	If Under 1 Year		24 Hrs. Min.	8. Date of Bir (Month, De	th V Veer)	9. Birt	thplace (State or Fo
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Funeral Director	4215 Cal	lborne R		cedent Ever in	0115 13	Was Decedent of F	dispanie Or	inin? (Spe	ectv Yes or No			erican Indian,
nu.	11. Marital Status	ried 2 Marrie	Armed F	orces?	110.5.	If Yes, specify Cubi	an, Mexica	n, Puerto	Rican, etc.)	- 1	Black, Whit	te, etc.
by F	3 Widowed		If Yes, G Year or I	ive		1 ☐ Yes 2 🛣 No	Specify			Sp	ecify: Afi	merican
ted		15. Decedent's			16a. Dec	edent's Usual Occup	pation	at at wards		16b. Kind	of Business	/Industry
ple	(Spe Elementary/Sec		grade completed,	(1-4or 5+)	life.	re kind of work done DO NOT use retire	d) auring mo	SI OF WORK	ny		-	
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Be	17. Father's Name	(First, Middle, L.	ast)						(First, Middle		mame)	
ToE	Richar	d Parker	•						da Hal			
	19a. Informant's N		ip (Type, Print)			iling Address (Street						Zip Code)
	Jo1ene			1=-		5 Colborne	e Rd					Town Ctata
	20a. Method of Dis		3 □Removal from		cemetery, cr	position (Name of ematory or other pla	ce)	01-1	9-04		,	Town, State
'		5 Other (Sp.			letro Cr	rematory		01 1	9 04	Balti	more,	MD
	21. Signature of F	uneral Service Li	icenado		-	22. Name and Addre		Wy	ie Fun	eral H	lome,	PΑ
	1//		/M	_		638 N Gi			Baltimo		2121	1
	Immediate Cause disease or conditi resulting in death	ion	_ a. Narcot	tic and	Ethanol	Intoxication		s cardiac o	or respiratory a	rrest,		
il Examiner		onditions, mmediate lerkjing tr injury ts	a. Narcot Due to c.	tic and o (or as a con				s cardiac o	or respiratory a	rrest,		Interval Between
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** GEORGIE PARENTI 4 12004 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GIOOD SAMARITAN HOSPITAL BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XX M 2□ F 77 220-12-4374 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 💢 💥 o Director BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **JEFFERSON** 125 AVENUE 21093 U. S. A. 23a by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1. December 2 □ No 1945 − If Yes, Give Year or Dates: 1946 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2) Yo Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) SALOON YEARS OWNER OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil Iment of Health and Mental H tant: If Itam 27 is marked oth NUNCIATE MIMOTTI PIETRO PARENTI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ELIZABETH PARENTI (WIFE) Α. 125 JEFFERSON AVENUE, COCKEYSVILLE, MD., 21030 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. HILLTOP SERVICE CORP 01-20-2004 TOWSON, MARYLAND, 21204 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME INC., TOWSON, MD., 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner ENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

o tha Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital tuneral director. after death. the

Certification: To Be

27. Manner of Death

Natural

2 Accident

3 🗀 Suicide

29a Certifier

4 Homicida

tilled in by within 24 hours a

To the Funeral C

completely tilled i Medical

10H

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

M

5 Pending investigation

6 ☐ Could not be

29c. License number

D0060687

GOOD SAMARITAN

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MD

31. Date filed (Month, Day, Year)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

			Please	Chata of Man					-	_	ble.	
			For State	State of Mar	yland /	•	icate of l			21	Int. nill	0
			Registrar 1. Decedent's Name (First, Middle, La	net)		Certif	icale of i	Dealit	2. Date of Dea	Reg. No. 👇 🍝	3. Time of Death	2
	Physicia /Medic	_	John Herbe	•	mphre	y J	r.		JANUAR	1 Day 8	2004 3. Time of Death 5.35 M	А
	Examin		4a. Fecility Name (If not institution, given North Arunder	\ \ \ \ \	_		SLEN	Bulule		ANNE	Λ.	
Ī	Funeral		5. Social Security Number 6.5	Sex 7. Age (In yrs. last b		Under 1 Year onths Days		8. Date of Birth (Month, Day Jun 1		Birthplace (State or Foreign Country) MD	חק
	Director		Usual Residence of Decedent						Juli 1	1730		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant. It a Medical Examir at mast be rollified at	tor	MD 10a. State 10b. County Anne Ar		0c. City, To	Glen	on Burnie				10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
,	with the	i Direc	10e. Street and Number 5815 Ritchie St	reet		1	10f. Zip Code 2106	51		10g. Citizen of	What Country?	
15	death ms 23	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was	Decedent of H	ispanic Origin? (Spe In, Mexican, Puerto I	cify Yes or No-	14. Rac	ce - American Indian, ck, White, etc.	_
. 7	urs after al', or Ite Evanime	Completed by Funeral Director	1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	1 Y Yes 2 No If Yes, Give Year or Dates:			Yes 2110 No	Specify:	nicari, etc.)		y: White	
t \ . 5-003	n 72 hours "natural", vulcel Ex	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	Sa. Decedent	's Usual Occup	ation during most of workii d)	ng	16b. Kind of B	usiness/Industry	
2121	within ene. than '	Jupi	Elementary/Secondary (0-12)	College (1-4or 5+)			mployec			Service	e Station	
	be filed with stal Hygiene d other tha event. Let	Be Co	17. Father's Name (First, Middle, Las	v)				18. Mother's Name	(First, Middle,	Maiden Suman	ne)	
12 F	2 should be and Mental Is marked c	To B	John Herbert Pun	phrey, Sr.				Margueri	te Ryde	er		
EN, John			19a. Informant's Name/Relationship Mr. John David Pu			_	ddress (Street a	and Number or Rura treet Gle	/Route Numbe en Burn:	-	, State, Zip Code) 21061	
PumPHREY Baltimore. Ma	- 7 5 5		20a. Method of Disposition XD Burial 2 Cremation 3 [☐Removal from State	ceme	-	on (Name of or or other place Memoria	🤋 Jan 2	22	20c. Location	- City or Town, State	
S in	permit. Pages Department of t Important: If ite any injury or of		*4 □ Donation 5 □ Other (Special Signature of Fune of Service Lice		Meado	_		1			1 Home, P.A.	
B	permit. Departr Importa) but to	mo1	1120		cond Av		n Burn		21061	
	Physician		3a. Part . Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition	S	CRMI		ne mode of dyin	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a c	consequenc	1						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury	b. Due to (or as a c	consequenc	e of):						
	e be executed sician and burial-transit	Examiner	that initiated events	c								
90.	be executed sician and burial-transit	al Ex	resulting in death) Last	Due to (or as a o	consequenc	e of):						
587	icate physi s the b			_ d								_
P.O. Box 68760.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. When Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 I 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal dea		topic pregnancy her <i>(specify)</i>	,			ate of delivery onth Day Year	
	ires that the de signed by the a	by	Part II. Other significant conditions	contributing to death but i	not resulting	g in the unde	rlying cause giv	en in Part I.		obacco use con	tribute to the cause of death?	m
CO	w require been sign	Completed							24a. Was	an 24b.	Were autopsy findings available prior to completion of cause of	le
Be	nysician: The law his certificate has I I director, page 2 s	dwo					·		autop perfoi 1 ☐ Yes	med?/	prior to completion of cause of death? 1 Yes 2 No	
ital Ital	stan: artifica ictor, p	Be C	25. Was case referred to medical examiner?				127	26. Place of Death				
of C	Physic this o	2	1 ☐ Yes 2 ☑ No 27. Mann of of Death	Hospital: 1 Inpatient 28a. Date of Injury		Outpatient o. Time of	3□ DOA Oth 28c. Injur	4 Nursing Hor		lence 6 Oth		
00	nding Ph th. : After th s funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	Year)	Injury	Wor	k?` Yes 2 □No				
Division of Vital Records.	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, street,	factory, office		28f. Location (S City or Tow		ber or Rural Route Number,	
1/	To the Hospital or Attentwithin 24 hours after death to the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of a miner: On the basis of ea and manner state	xamination :	dge, death oc and/or invest	curred at the tir tigation, in my o	me, date and place, a pinion, death occurr	and due to the ded at the time, a	cause(s) and madate and place,	anner as stated. and due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	Wille I	74 1	7 D.	29c. Licens	e number	-	29d. Date signe	ed (Month, Day, Year)	
	10		30. Name and address of person who			a) (Tuna Prin	pital (Digita (la R	Lymio I	18: 2004 Taylord 2106	1
	<u> </u>		0-0.				1100	Vive, G	ien No	v · ite		-
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0 20	04	A.	Roman	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Pate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 215 Year Honth Day ula **Physician** ober 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner N/A MERCY MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/3/28 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number Days **Funeral** Hours 1 MM 2□ F 75 MARYLAND 220-22-5484 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 503 S. ANN STREET 21231 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1⊠Yes 2 □ No If Yes, Give Year or Dates:KOREA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or iter any njury or other traumatic event, it a Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATOR** BALTIMORE CITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PETER PULA FRANCES NOWAKOWSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MS. EDITH PULA/ DAUGHTER BALTIMORE, S. ANN STREET MD. 21231 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State HOLY ROSARY CEME. 1/16/04 DUNDALK, MD. * 4 ☐ Donation 5 ☐ Other (Specify) KACZOROWSK FaciliFUNERAL HOME P.A. 21. Signature of Euneral Service Lice cut BALTIMORE 21224 MD. 23a. Part1. Enter the disease, or complications that caused the shock, or heart lailure. List only one cause on each line. Do not enter the mode of dying, such a cardiac or respiratory arrest, death 8 Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner his certificate has been signed by the attending physicien and director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. Il ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Inknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2□ No Xes. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 1 Yes the funeral 28a. Date of Injury (Month. Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide Hospital 🗺 Certifying Physicien: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Leause of death (Item 23a) (Type_Print) and address of person who enns

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

		1 - For INPEND ITEM 23a,PI	State of Maryland / D II,27&28 G827 1/22/04	Certificate of De	eath	Reg. No. 2004 011				
		Decedent's Name (First, Middle, Last			2. Date of D	1 1 1				
Physici		Catherine	Marv	Powe11	JANUAF	Day Year				
/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Loc		4c. County of Death				
		5004 ELLIOTT STRE 5. Social Security Number 6. Se		ST. LEONAR	RD	CALVERT				
Funeral Director		5. Social Security Number 6. Se 219–72–6365	TH OTHER		ours Min. 8. Date of Bi (Month, 1)	3, 1960 9. Birthplace (State or Fo				
death with the Maryland ms 23a or 28a-1 show rmust be natified at	'n	10a. State 10b. County	10c. City, Town			10d. Inside City L				
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23a o	alD	5004 Elliott Stre	et	20685		United States				
SW SW	nei	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispan	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)					
yor is not a should be new within 72 hours after beath with the Marylan to the Habiltand Mental Hygiene. If frem 27 is marked other than "natural", or frems 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		pecify:	Black, White, etc. Specify: White				
within 72 h ene. than natu	pletec	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Decedent's Usual Occupation Give kind of work done during life. DO NOT use retired)	g most of working	16b. Kind of Business/Industry				
h and Mental Hygiene. 7 is marked other than "traumatic event, Lie Med	E O	12	College (1-4or 5+)	Waitress Food Service						
a H	Be (17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle	, Maiden Sumame)				
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aalth and n 27 is m ier traum		John Harris Bro	ther 19b. 1	Mailing Address (Street and N 07 Bragg Road	Number or Rural Route Numb , Fredericksb	er, City or Town, State, Zip Code) urg, VA 22407				
Department of Health Important: If item 27 any injury or other tri		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ F	Removal from State cemetery.	Disposition (Name of crematory or other place)	Dete	20c. Location - City or Town, State				
ant and		`4 □Donation 5 □Other (Specify)	-	w Crematory		04 Baltimore, Maryla				
Departr Import any inj		21. Signature of Fu 11 ervice Li // s	66 1	22. Name and Address of	Facility Found and	Sons Funeral Chapel				
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this certific	Be	25. Was case referred to medical examiner?		26. 1	Place of Death (Check only of					
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Direction by in by	artif	4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	*	City or Tox					
within 24 hours after o To the Funeral Direct completely filled in by	edical Ce	(Onech only 2 x medical cxaiiiii	FOUND AT HOT sician: To the best of my knowledge, or per: On the basis of examination and/or	leath occurred at the time, da	te and place, and due to the	OTT ST. ST. LEONARD ,MD Cause(s) and manner as stated. date and place, and due to the cause(s)				
within 24 hours a To the Funeral I completely filled	Medi		and manner stated.							
= = =	_	29b. Signature and title of certifier	000	29c. License num		29d. Date signed (Month, Day, Year)				
To		39-Name and address of parson who co	conica-tollo	Jens OCME		JANUARY 11, 2004				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15<u>, 2004</u> JANUARY **Physician** PARSON 5:20 A STANLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **BALTIMORE** BALTIMORE MANOR CARE RUXTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 22, 1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1₩ 2□F **Yrs** MD 73 213-26-5302 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and terms 23 eor 28s-1 ehow ant: If item 27 ie marked other than "naturel", or Items 23 eor 28s-1 ehow 10d. Inside City Limits 10c. City, Town or Location 10a State r than "naturel", or Itams 23s or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo BALTIMORE MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 U.S.A. 3303 TIMBERFIELD LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR DRY CLEANING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **PARSON** WOHL GLADYS LEON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3303 TIMBERFIELD LANE - BALTIMORE, MD 21208 SONDRA PARSON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) OHEB SHALOM MEMORIAL | 1/18/2004 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 1am 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart infilture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYELOMA **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-t Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗆 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Alter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of contines D-12849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. TOWSON MD 21204 4.4 GHILADI. MID. 7600 OSLER 31. Date filed (Month, D. 32 Registrar's Signature Registrar

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F	naval		Union Hospita 5. Social Security Number	6. Sex	7. Age (In yrs. last t	birthday)	If Under 1		If Under		8. Date of Birt	h	Cecil 9. Bi	rthplace (Sta	ite or Foreign
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)		30. Name and address of person	who completed cause	e of death (Item 23a	(Type, F	Print)	Ell	kton	/	D 21	921	1		
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Baltimore,	Page ment o ant: If ury or		1 🏋 Burial 2 ¹ 4 □ Donation	bert E Porter 10505 Cash Road Berlin, Maryland 21811 Method of Disposition Method of Disposition Signature of Cermation 3 Removal from State A Condition 5 Other (Specify) Signature of Funeral Service Licensee 20b. Place of Disposition (Name of cermatory or other place) Parkwood Cermetery January 15 2004 Baltimore, Maryland 22. Name and Address of Facility Lassahn, Funeral Home Inc														
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	St Regist	ate rar	31. Date filed (Mo	IAN 1	-	104 32.1	Registran's Sig	-a /	5	Som	rida /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 10:30am **Physician** Winfred J. Rohe Jan 16 2004 /Medical 4c. County of Deeth 4h. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Joseph Richie House Baltimore If Under 1 Year II Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number **Funeral** Hours Days **X** 3 2 □ F 74 Yrs Maryland Aug24,1929 214-24-3324 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at MD Baltimore 1 ☐ Yes 2√ No Rosedale Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 34 Royal Ann Court 21237 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2√ No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White 2 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Sunpaper Paper Handler 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Rohe Elizabeth Rowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Auffarth/daughter 35 Yew Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State BayviewCrematory 1/17/04 Baltimore MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 21. Signature of Funeral Service Licensee Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearl failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final (ance · yeur una **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: esn nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ŏ in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 2 No 3 Probably 4 ☐Unknown √ Yes Completed peeu; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 V Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Douth 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 1 Naturai 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. after death Diractor: 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29h Signature and title of certifier 0 24321

State Registrar

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31. Date filed (Month, Day, Year)

10:20 Am

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Regist

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Formula Control Cont		/Medi	cal		DJA	Nº	15 2001	1
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Secondary Golden Programme Colored C		death ms 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	Origin? (Specify Yes	or No-	14. Race - Ame	
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Physician / Medical Examinary Physician / Medical Examinary				23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such a	s cardiac or respirat	ory arrest,	OTUMDIA	Approximate
Due to (or as a consequence of): TVI NUI Security Securit				disease or condition	VEUMA	n11	A	Onset and Death
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Comparison of Positive Properties Control of Positive Properti	Vita	ician: sertific ector,	Be	examiner?				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABCDA KHAN State 31. Date filed (Month, Day, Year) 32/7 Registrar's Signature		Phys r this ral dir	-7	1 Mulnpatient 2 ER/Outpatient 3 DOA 4 N				ify)
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State 31. Date filed (Month, Day, Year) 32, Registrar's Signature	N.	5		Mulda Hu Khan M.D. 143	5523	1):	AN. 16	2004
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ORIGINAL

			1 - For State Registrar	State of M	aryland	-	artmen rtificate					Reg. No.	200	4 01127
	Physici	an	1. Decedent's Name (First, Middle, L.	•	inson						2. Date of De Month	Day	Yea	
	/Media	ai	Bernard Wes				4h Cihr	Town or	Location of	of Death	Januar		2004 County of De	
	Examir	er	811 Brunswick Ro		,			sex	Location	or Death			altimo	
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Bir			Birthplace (State or Foreign
	Director		217-18-3619	1□XM 2□ F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da SEP 18	, 192	.3 M	aryland
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Aaryla f sho	5		ltimore			sex							1 ☐ Yes 2 ☑ No
	28e-	rect	10e. Street and Number		1		10f. Zip	Code				10g. Citize	en of What	Country?
	h with		811 Brunswick	Road Apt.	1 B			2	1221				USA	
36	permit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any righty or other traumatic event, the Medical Examinational be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Types 2 If Yes, Give Year or Dates:	?	1	Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:		ecify Yes or No Ricen, etc.)		4. Race - A Black, W Specify:	merican Indian, Thite, etc. White
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Ba	permi Depa Impo any in	10	Date (MV)	Donald N	March	2	remat 99 Fr	ron eder	Socie ick R	ery c Road	Baltin	land,	Inc.	1228
h	1		23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that cause v one cause on each	ed the death.									Approximate Interval Between
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	/Medical Examiner		resulting in death)		s a conseque									
· į	Lxammer	بيد	Sequentially list conditions,	b. Construction	5 a Cunseque	nea A								
	ted nsit	Examiner	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 0	s a somooquo	1100 01).								
•	execu n and al-tra	Exar	that initiated events resulting in death) Last	Due to (or a	s a conseque	nce of):								
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P.O. Box	if the death certificate be executed by the attending physicien and tached for use as the burrat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\times \) Yes \(2 \) No \(9 \) Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Fetal d	eath 3	□Ectopic pa □ Other (sp				52501	23	3d. Date of o	delivery Day Year
	tha de	by Pr	Part II. Other significant conditions	contributing to death	but not resulti	ing in the u	ınderlying d	ause giv	en in Part I	l.	23e. Did	tobacco us	e contribute	e to the cause of death?
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Division	f or Attending after death. Director: After	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of li	njury - At hom etc. <i>(Specify)</i>	e, farm, st						(Street and wn, State)	Number or	Rural Route Number,
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Å			30. Name and address of person wh						0.4		201 4	3 0	100	7
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ORIGINAL

			For	State of Ma		d / Depa	artme	nt of H	lealth a		-		_	. 0 1	120
			1 - State Registrar			Cei	rtifica	te of L	Death			Reg. N	o. <u>C. U.U.</u>	9 U1	160
	Dhycini	20	Decedent's Name (First, Middle,	Last)							2. Date of I Month		ay Year	3. Time	
	Physici /Medic		Grace Lynn Robin	nson							Jan		3, 2004	8:35	A M
	Examin		4a. Facility Name (If not institution, g	give street and number)			4b. City	, Town, or	Location of	f Death			c. County of Deat	h	
			Carroll Hospital					mins			,		Carroll		
	Funeral			. Sex 7. Ag 1 ☐ M 2 ☐ F		last birthday)	If Und Months	Days	If Under 2 Hours	Min.	8. Date of I (Month,	Day, Yea	r) 9. Birt	hplace (State ountry)	or Foreign
	Director		212-80-0685	10 M 281	42	Yrs.					Sept.	30,	1961 Wes	st Virg	inia_
	D *		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	cation		·	-				10d. Inside (City Limits
	anyla shov	-													s 2 No
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	ath with the Marylan 123a or 28e-f show ust be notified at	Directo	10e. Street and Number					ip Code				10g. C	Juizen of What Co	uritry r	
	72 hours after death with the Maryland Insturat; or ttems 23a or 26e-f show diest Examinationst be notified at	<u>ra</u>	172 Pennsylvania		- 11			157	11-0-1-	-:-0 (0-	if. V		ted Stat		
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.5. 13.	was Dec If Yes, sp	ecify Cuba	ispanic Origin, Mexican	, Puerto	ecify Yes or Rican, etc.)	NO-	Black, Whit		
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<u></u>		Be c	John Benjamin Ro						Marv	Jua	nita N	(au 1			
<u>-</u>	d 2 should by th and Menta 7 Is marked treumatic ev	၉	19a. Informant's Name/Relationshi			19b. Maili	na Addre	s (Street					or Town, State, 2	Zip Code)	
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Baltimore, Maryland 2	1 an Heal em 2 ther		20a. Method of Disposition	iid)	20b. F	Place of Dispo					Date	4	Location - City or	Town, State	
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	/Medical Examiner	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. VENTRIO Due to (or as b. Due to for as	a consequence	uence of):	, M	veta	Mto	elic				44	ean
,09	te be executed ysician and se burial-transit	cal Exa	resulting in death) Last	Due to (or as	a conseq	uence of):									
	icate phys s the			d											
Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	⊒Ectopic ⊒ Other (pregnancy specify)	′			-	23d. Date of de Month	livery Day	Year
٦.	that I ed by detar	된	Part II. Other significant condition	s contributing to death b	ut not res	ulting in the u	ınderlying	cause giv	en in Part I.		23e. Di	d tobacco	use contribute to	the cause of	death?
Ś	sign d be	5	Romal to	eiloure							1 (Yes	2 Ŋ N6 3 □ Pi	obably 4]Unknown
Ö	requ	etec	- College						-		24a. W		24h Moro o	atopsy finding	c available
l Rec	The law ate has b page 2 s	Compi									au	topsy rformed?	prior to death?	completion of	cause of
/ite	cian ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	er.		h (Check on				
\leq	hysi this o	P	1 ☐ Yes 2 ☐ No	1 Lightnpatie		ER/Outpatie		JOA	4 🗆 140				6 ☐ Other (Spe	cify)	
=	ng P	9	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time o Injury		28c. Injur Wor			28d. Descrit	e now in	jury occurred		
Divisio	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	ot be 300 Blood of In	jury - At h tc. (Speci	ome, farm, st fy)	M reet, facto		Yes 2 □			(Street Town, Sta	and Number or R	ural Route Nu	mber,
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	ro th within ro th	Me	29b. Signature and title of certifier					9c. Licens				29d. [Date signed (Mont	h, Day, Year)	
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	Λ		30. Name and address of person w	A		m 23a) (Type	, Print)								
	. /			IAPAANNA V	10 -	WA.		e Ro	d WE	STMI	NSTER	- Y	1D S	1112.	/
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1	Regist		JAN .	2 0 2004 1	185000	19	A Section	PALL!							

		For State Registrar	State of Ma	ryland	•	artment of I				ene g. No.	04	01129
		Decedent's Name (First, Middle, La	st)		******				Date of Death	Day	Year	3. Time of Death
Physici /Medi		Shirley Paulin	ne Ringley						anuary		2004	17:20 M
Examir		4a. Facility Name (If not institution, given 6825 White Rock				4b. City, Town, C	ykesv	ille		4c. Count	of Death Carr	
Funeral Director		214-20-6059		(In yrs. last 78	birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. I	Date of Birth Month, Day, an 11,	1926	9. Birthp Cou	place (State or Foreign ntry) ID
pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
Aarylan Fahow	ō	MD Carro		,		kesville						1 ☐ Yes 2 ☐ No
the 28a-	Director	10e. Street and Number			Э	10f. Zip Code			10	g. Citizen of	What Cou	ntry?
3a or		6829 White Rock	Road			2	1784			US	A	
fter death	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No			Was Decedent of I			Yes or No- in, etc.)	14. Ra		can Indian, etc.
ie, Incl y latin 2.12.13-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. I Health and Mental Hygene. Item 27 is marked other then "natural; or items 23a or 28s-f show other traumatic event, the May cal Examiner matche notified at	þ	3 ☑ Widowed 4 □ Divorced 15. Decedent's E	If Yes, Give 12 Year or Dates:		6a. Deced	1 ☐ Yes 2 ☑ No	pation		1	Specif 6b. Kind of B		hite dustry
dithin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	+)	life.	kind of work done DO NOT use retire [omemaker	ed)	st of working		D		·
led w lygier her ti		17. Father's Name (First, Middle, Las.	p1			omemaker		er's Name (Fi	ret Middle M	Dome:		
Lal y lattu K. L. L. Should be filed within and Mental Hygiene. Is marked other then aumatic event, Ille M.	To Be	Howard G. John	ison				M	attie '	V. Rida	gley		
IVICAL IN and 25 ho 127 is m		Ms. Paulette Ring				ng Address <i>(Stree</i> White R						
thealth Health Item 27 other tra		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of matory or other pla		Date		Oc. Location		
Pages nent of I		P☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		Lake	e Vie	w Mem. P	ark	1/21/04	4 5	Sykesv	ille,	MD
partition of permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		21. Signature of Funeral Service Lice	HALLOF	1	Ĥ	AIGHT FU ykesvill	NERAL	HOME 8	CHAPI	EL, PA	(Box	195)
Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Met	the death. I	Do not ent		ing, such as				+00	Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (briss a	i consaquen	ice of):							
cate be executed physician and sthe burial-transit	dicai Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequen	ice of):						7	
I necolds, r.C. box 600. The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	2 Fetal de	ath 3[Ectopic pregnand Other (specify)	ey .				ate of deliver	ery Day Year
uires that signed b	by P	Part II. Other significant conditions	contributing to death bu	it not resultir	ng in the u	nderlying cause gr	ven in Part	l.	23e. Did toba		tribute to t	he cause of death?
law requires as been sign 2 should be	Completed								24a. Was an autopsy		Were auto	opsy findings available impletion of cause of
	Nom								perform	ed? ©∕Ño	death?	20 No
VICAL MEC SICIAN: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?						e of Death (C	heck only one			
OI VILA Physician: r this certific ral director,	ို	1 ☐ Yes 2 X No	Hospital:		VOutpatier	IL 3 DOA		ursing Home				Daughter's
of the state of th	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	-	Year)	Bb. Time of Injury	M 1 C	Yes 2]No	Describe how			Home
blor Att	ertiff	3 Suicide 6 Could not 4 Homicide determined		iry - At home :. <i>(Specify)</i>	ə, farm, str	reet, factory, office		28f.	Location (Stri City or Town,		ber or Rura	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fr	edicai C		hysician: To the best of miner: On the basis of and manner state	examination								
omple	Med	29b. Signature and title of certifier	. //-			29c. Licen	se number		29	d. Date signe	d (Month,	Day, Year)
F S F 0		> Will (116	0		Doo	68	137		1/1	9/00	1
10		30. Name and address of person who	completed cause of de	eath (Item 23	За) (Туре,	Print)	7.0	- 3 7	1	CLE	11	1
W		Wilbur Kus,	295 St	Act.	Au	551 9	07	West	m.ns	teril	MO	21157
St	ate	31. Date filed (Month, Day, Year)	2 U 2004 Begistra	r's Signatur	0	ST. A. ST. ST. ST. ST. ST. ST. ST. ST. ST. ST	Car.			(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death .13,2004 Year **Physician** FRANK RADULEWICZ JAN 12:05 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 502 S. MACON STREET BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 X M 2 □ F 216-32-6745 Yrs. 84 28,1919 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Director XXYes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 S. MACON STREET 21224 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1942-43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
5 College (1-4or 5+) SELF-EMPLOYED UPHOLSTERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STANLEY RADULEWICZ EMILY UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. MACON STREET, BALTIMORE, MD. MELANIE JENKINS/ FRIEND 502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1/17/04 ' 4 Donation 5 Dother (Specify) BAYVIEW CREMATORY BALTIMORE, MARYLAND 22. Name and Address of Facility LILLY & ZEILI 21. Signature of Funeral Service Licensee JLLY 00 S 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hronic 3 years

Physician /Medical **Examiner**

Funeral

Director

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinational by mailied at once.

Baltimore, Maryland 21215-0036

this After Director: filled in by

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	resulting in death)	Due to (or as a consequence of		
IICAI CYAIIIIIEI	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d		
ysicial vine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
חובובה הא זי	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	2 In No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of
5			performed? 1 ☐ Yes 2 🗗	death?
2	25. Was case referred to medical examiner? 1 ☐ Yes 2 【② No	26. Place of Death Hospital: 1		6 □Other (Specify)
allon.	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	
201111111111111111111111111111111111111	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
le di	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurre	and due to the cause(and at the time, date an	s) and manner as stated. nd place, and due to the cause(s)

29c. License number

D0058779

29d. Date signed (Month, Day, Year)

ST

BALTIM

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral L

29b. Signature and title of certific

30. Name and address of person

31. Date filed (Month, Day,-Year

who completed cause of death (Item 23a) (Type, Print) ASAMON

Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 1520 M **Physician** January 15 2004 Marie Raeke Juanita /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 🛛 F June 9, 1922 Maryland 213-16-5117 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2 ☑ No Joppa Harford Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 USA 1116 Clayton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important; if item 27 ie markad any injury or other treumatic ev once. and Mental Annie (unk) Evans Allen Dill Edgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1114 Clayton Road, Joppa, Maryland 21085 Raymond C. Raeke, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 1/23/04 Bel Air, Maryland 21. Signature Fungal Service License McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner insure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): OP that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 Woo 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) Ö of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be AEKE. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Claudia A. Kroker, MD, FACP

Wa

29c. License number

500 40

29d. Date signed (Month, Day, Year)

01-16-04

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 19a per FH,G827,01/20/04dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year Month **Physician** HOWARD DELANEY RAWLINGS JANUARY 8:21 AM 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner STELLA MARISS@ MERCY HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Days Months 1 M 2 □ F Yrs. 7-26-1936 213-32-3842 Usuel Residence of Decedent MARYLAND Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene.
Important: If item 27 is marked other than "naturel; or items 23a or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No MD. N/A BALTIMORE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 603 N. CALHOUN ST. 21217 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 11万 Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry $\mathcal{HMUL}\mathcal{NGS}$ Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) -12SUPERVISOR INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be WILLIAM RAWLINGS IRMA HATTEN 19a Informant's Name/Relationship (Type, Print)
DOROTHEA RAWLINGS
DOREATHA RAWLINGS (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 N. CALHOUN ST. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation Jo ☐ Other (Specify) GARRISON FOREST VETERANS 1-23-2004 OWINGS MILLS, MD. 21. Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and I for use as the bunal-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 TVUS 2 MU 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ဥ 2(No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 16/2004 10854 30-Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

State

Registrar

Division of Vital Records, P.O. Box 68760.

PAUL

Rischera

2004

31. Date filed (Month, Day, Year) JAN 2 0 2

32. Registrar's Signature

Baltimore

			For State Registrar	State of Marylan		nent of H cate of L		ental Hygie Reg.	2006	01133
	4		Decedent's Name (First, Middle, Last,)				2. Date of Death		3. Time of Death
_	Physici		Dolorese PE	THERINE	SHAF	ESR	+.	Month JANUAR	Day Year	3:22 A' M.
	/Medic Examir		4a. Facility Name (If not institution, give			. City, Town, or	Location of Death		4c. County of Death	0.00
			GURHRIST I	INIER		Tows	100		BALTIN	NORI
	Funeral		Social Security Number 6. Sec. 15. Social Security Number 6. Sec. 15.		M	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	olece (State or Foreign
	Director		38 32 1641	M 280F 67	Yrs.			1AN. 15 10	137 CAR	ONALK
_	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location	on				10d. Inside City Limits
	arylan ehow	ō	2001/00/00	00	-					1 ☐ Yes 为 No
	the Mi	Director	10e. Street and Number		21 152	Of, Zip Code		10a	Citizen of What Cou	ntrv?
	th with 23a or		3327 DUBL	~ C) ~~~ C	-00	0.11	NI		.0211	,
	ter death tems 23	Funerai	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was	Decedent of Hi	spanic Origin? (Spec	rify Yes or No-	14. Race - Ameri	can Indian,
G	urs after death with the Maryla et; or tems 23a or 28e-f ehov	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 250 No			n, Mexican, Puerto R	ican, etc.)	Bleck, White,	etc.
03	ref.,	1 by	35⊈ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		Yes 253 No	Specity:		Specify: W)	115
21215-0036	within 72 hours jiene. r then "naturel", the Medical Ex	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent (Give kind	of work done a	luring most of workin:	9 161	b. Kind of Business/In	dustry
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_ ∑	shoul nd M mari	T ₀	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailing A	ddress (Street a	and Number or Rural	Route Number, C	ity or Town, State, Zij	Code)
	od 2 27 ts	Ì	MARK Shallof - "	1405	3327	Outhur	MAKINE P.A	SUPPORT	MA 211.	54
و	of Head		20a. Method of Disposition		Place of Disposition	n (Name of	(a) Da	ite 200	. Location - City or To	own, State
E	Pages nent of l int: If its		7 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	RKWOO	1/2		81 8	akille (malleal
Baltimore	permit. Pag Department important: I eny injury o		21. Si ma re of Funeral Service Licens	-		me and Addres		15 MOR	72	466
00	Depariment impo	1	Grand Arrow		83	JE 00	REGRO (ROAD PA	BKVILL Y	lardrano
			23a. Pert1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the deat ne cause on each line.	h. Do not enter th	e mode of dying	g, such as cardiac or	respiratory arrest.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mctas behic	gallbi	adder	concer			Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a consec				-		J
Am	LAdminer	_	Sequentially list conditions	b. Due to (or as a consec	unage of:					
33	ted	Examiner	Sacuar tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D00 10 (01 as a consec	derice ory.					
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7	th by cat	edic		u						
2 ×	eath certific attending p	N/	230. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delive	ery
	The law requires that the death certification is the standard of the standard	Physician/Me	in the past 12 months? 1 \(\sum \) Yes 2 \(\overline \) No	1 Live birth 2 Fete 4 Pregnant at time of c 9 Unknown		opic pregnancy ner (s <i>pecify)</i>			Month	Day Year
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Sord	v requir been s	Completed					·	1 Tes	2 No 3 Prot	pabły 4 ⊠©nknown
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- 1	this aldi	10	1 Yes 2 Alo	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 28b. Time of			e 5 Residence Bd. Describe how	e 6 Dether (Specif	n hospice
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ffe ivision	Attending in death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, street.			3f. Location (Stree	t and Number or Rura	al Route Number,
3	ipital or Al ours after ours after eral Direc	Certification:	4 Homicide	building, etc. (Special	(y)			City or Town, S	rate)	
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	iai	29a. Certifier (Check only 2 Medical Exami	sicien: To the best of my kno	owledge, death oc	urred at the tim	e, date and place, ar	nd due to the caus	e(s) and manner as s	tated.
W 8	To the Hos within 24 h To the Fur completely	edical	one)	ner: On the basis of examina and manner stated.	tion and or myest					
	To the within To the comple	Σ	29b. Signature and title of certifier	~		29c. License	number	29d.	Date signed (Month,	Day, Year)
	ĺ		Mary and	~~~ <u>`</u>		N > 0	3V)	7	LUCIAN 11	2009
	D		30. Name and address of person who co	ompleted cause of death (iter	n 23a) (Type, Prin	St 6	Saltmore	mo 2	1204	
	Sta	10							/	
	Regist		31. Date filed (Month, Day, Year)	2. Registrar's Sign	Jack.					

			For State	State of Marylan				lental Hygi	ene 2001	. 01121
			Registrar		Certific	cate of De	eatn	2. Date of Death	g. No. 4 UU	3. Time of Death
Н	Physicia	an	Decedent's Name (First, Middle, Last,		INMAN	3		Month	Day Yeer 1.7 200	
	/Medic		DOROTHY 4e. Facility Name (If not institution, give			City, Town, or Loc	cation of Death	JAN	4c. County of Dea	
	Examin	er	Worthinston				USON		BALT	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If L	Inder 1 Year If	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,	9 Bir	thplace (State or Foreign
1 2	Director		139-05-7215	IM 20 F 88	Yrs.	illis Days r	TOUTS WITH.	SERT 3.		YA.
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Location	1				10d. Inside City Limits
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	28a-	Director	10e. Street and Number	110014	-	f. Zip Code		10	g. Citizen of What Co	ountry?
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	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was I	Decedent of Hispa , specify Cuban, N		pecify Yes or No-	14. Race - Ame Black, Whit	
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003	J within 72 hours after death with the Maryland Jiene. r then "netural", or Items 23e or 28e-f ehow The Medical Exeminer must be nevities at	d by	3 Widowed 4 Divorced	Year or Dates:				Т.	16b. Kind of Business	Mile
Maryland 21215-0036	within 72 ene. then *nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give kind	Usual Occupation of work done durin OT use retired)	ng most of work		TOD. KING OF BUSINESS	rindustry
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lan	s 1 and 2 should F Health and Men item 27 is merke other treumatic		19a. Informant's Name/Relationship (T		19b. Mailing Ad	dress (Street and			City or Town, State,	Zip Code)
	and fealth m 27	1		ACOB 20h E	3 4 o 4 \ Place of Disposition	HUSS AV	K BY	Date (M)	としょうり 20c. Location - City or	Town State
Baltimore,	00-		20a. Method of Disposition Burial 2 Cremation 3 🔲	Removal from State	emetery, cremator	y or other place)	1 2	1	In the	" II DA
Ħ	permit. Page Department Importent: It any injury o		*4 □Donation 5 □ Other (Specify,		LINGTON 22 Na				DREXEL H	CATO
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68	Physician: The law requires that the death certificat rethis certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Jed	IF FEMALE:							
Вох	ith ce itendii or use	Physician/Med	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	ıl death 3 □Ecto	pic pregnancy			23d. Date of de Month	livery Day Year
о. В	it the dea by the a tached fo	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	leath 5∐ Oth	er (specify)				
<u>α</u>	that If	P.	Part II, Other significant conditions of	intributing to death but not res	sulting in the under	ying cause given i	in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Vital Records,	uires the signed id be de	Completed by	PMIKINSEN'S &	1SCASE				1 🗆 Ye	s 2 € No 3 □ P	robabiy 4 🗀 Unknown
cor	w require been si should I	ete	CHANNIC AR	PIGATION				24a. Was a	24b. Were a	utopsy findings available
Re	: The law cate has I . page 2 s	F						autops	ned?// death?	completion of cause of
tal	ician: Th certificate rector, pag	a	25. Was case referred to medical			20	6. Place of Dea	1 Yes 2 th (Check only on-		
Ξ	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other:	4 Nursing H	ome 5 Reside	nce 6 Other (Spe	poity) PSSISTIANT
n of	ding Ph h. After th funeral		27. Manu of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Manth, Day Year)	28b. Time of Injury	28c. Injury at Work?	NA	28d. Describe ho	w injury occurred	J
Sio	ttendin death. ctor: Aft y the fur	catio	2 Accident investigation 3 Suicide 6 Could not be	NA	NA		s 2 □No			
Division	after d	Certification:	4 Homicide determined	28e. Place of Injury · At h building, etc. (Special	ome, farm, street,	actory, office		City or Town	reet and Number or R . State)	urai Houte Number,
5,	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical O	29a. Certifier 1 Certifying Ph	/sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occ ation and/or investi	urred at the time, gation, in my opini	date and place, ion, death occur	, and due to the ca rred at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	o the	₩.	29b. Signature and title of certifier			29c. License ni	umber	2	9d. Date signed (Mon	th, Day, Year)
	- s + ō		Deuns C1	Clawrip		D250	010	D	nursy 19,	2004
.*	5		30. Nam and address of person who	completed cause of death (Item	m 23a) (Type, Print)		7	0 /	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign						
	Regist		JAN	20 2004	was for	Book	,			
DF	IMH 17 Rev 1/2	2001		•						

DHMH 17 Rev 1/2001

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SCHEMIST

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death Amend Item#18perFHG828 2/3/2004 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** С. SIMMS MATILDA 01 16 - 2004 8:30 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARKVILLE CREST CARE CENTER BALTIMORF Atilda Simms 1/16/2004 8:300/ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 1/2 1X F 215-14-0192 79 Yrs Director 12-11-1924 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at PARKVILLE MD. BALTIMORE 1 ☐ Yes XX No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8820 BOULEVARD 21234 WALTHER U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 (X) Married 1 ☐ Yes 2XXNo Specify: WHITE Specify. ģ 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME OWN HOUSEWIFE YEARS 10 Pages 1 end 2 should be filed v nent of Health end Mental Hygie int: If Item 27 is merked other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) CONSTANTINE BALDYGA CATHERINE ULRICH Giza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD B. ULRICH (NEPHEW) 11971 HARFORD ROAD, GLEN ARM, MARYLAND, 21057 or other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.STÁNISLAUS CEMETERY 01-19-2004, BALTO., MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Physiclan/Medical Examiner use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be deteched 3 Probably 4 → Unknown 1 ☐ Yee 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No Medical Certification: To 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this certificate To the Hospital or Attending Phwithin 24 hours efter death.
To the Funeral Director: After this completely filled in by the funeral

1 🗆 Yes 2 □ No investigetion 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifie signed (Month, Day, Year)

28c. Injury at Work?

30, Name end edocess of person who completed cause of eleeth (Item 23e) (Type, Print) when The MW

5 Pending

ethen 8500

Md2123

28d. Describe how injury occurred

State Registrar

27. Menner of Death

1- Natural

32 Registrer's Signature

28e. Date of Injury (Month, Day Year)

28b. Time of

			1 - For State Amend Item 16a p Registrar	State of Mary per FH,G827,01	land / Depa /20/04date	artment of H	ealth and M Death		ene g. No. 2001	+ 01137			
	Physici /Medic		1. Decedent's Name (First, Middle, Last MICHAEL	JAMES	STAC			2. Date of Death Month	13 200	4 950 AM			
g ga	Examin Funeral	er	4a. Facility Name (If not institution, give DOHNS HUPKINS BA 5. Social Security Number 6. Se	XYVIEW x 7. Age (In	yrs. last birthday)	BALTIMO If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	4c. County of Dea	rthplace (State or Foreign			
ž.	Director		040-26-0629 Usuel Residence of Decedent 10a. State 10b. County	100 2□F 70	Yrs.	Months Days	Hours Min.	9-22-192	GT CT	10d. Inside City Limits			
	be filed within 72 hours after death with the Maryland that Hygiene. ed other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	il Director	MD HARFORD 10e. Street and Number 4700 K WATER PAR	K DRIVE	BELCAMP	10f. Zip Code 21017			g. Citizen of What C	1 ☐ Yes 2 No ountry?			
USO	urs after death	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? ↑ Yes 2 No If Yes, Give Year or Dates: 19		Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 XNo			14. Race - Am Black, Wh Specify: WH	ite, etc.			
21215-0036	within 72 hou iene. r then "netura the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired,	furing most of work Master Ser	geant	6b. Kind of Business	,			
Maryland 2	should be filed and Mental Hygis s marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) MICHAEL JOSEPH ST		10h W.		KATHLEEN	e (First, Middle, M N SHEEHAN	aiden Sumame)				
	s 1 and 2 sh of Health and item 27 Is m other traum		19a. Informant's Name/Relationship (T) KIERSTEN BRAM — DA 20a. Method of Disposition 1 □ Burial 2 ★Cremation 3 □ F	UGHTER 2	139 W	OODS WAY,	PASADENA	MD 2112	City or Town, State, 2 0c. Location - City of				
Baltimore,	permit. Pages 1 and 2 should by Oppartment of Health and Menta Important: If item 27 is marked any injury or other traumatic et once.		'4 □ Doration 5 □ Other (Specify) 21. Signature / Emeral Service Licens	C:	2:	E CREMATION AND A NAME OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	s of Facility SIN	GLETON F	TEVENSVIL UNERAL HON NIE, MD 2	ME P.A.			
	Physician		27a. Part 1. Enter the disease, or comp shock, or heart failure. List only o immediate Cause (Final disease or condition	ications that caused the ne cause on each line.	death. Do not en					Approximate Interval Between Onset and Death MINUTES			
	/Medical Examiner	her	Vesulting in death) Due to (or as a consequence of): HYPOX EMIA Due to (or as a consequence of): Due to (or as a consequence of): Cause. Enter Underlying Cause. Disease or injury										
8760,	cate be executed physician and the burial-transit	Icai Examiner	that inflitted events c. The consequence of the con										
P.O. Box 68/	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	regnancy Fetal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of de Month				
	w requires that I been signed by should be deta	ted by Ph	Part II. Other significant conditions co	E PULMUNAT	ly DISOA	SE, SEVEN	Æ	23e. Did toba	_	o the cause of death? Probably 4 Unknown			
al Hecc	Physician: The law r this certificate has be al director, page 2 sh	e Completed	MALNUTYUTION, Po	evu?Hevlac	VAGCULA	n Diseas			ed? prior to death?	utopsy findings available completion of cause of s			
Division of Vital Records,	Attending Physicia or death. ector: After this cert by the funeral direct	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1-Anpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury	f 28c. Injury Work	er: 4 Nursing Ho	th (Check only one ome 5 Resider 28d. Describe how	ice 6 Other (Spe	ecify)			
Š	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined 29a. Certifier Certifying Phy	28e. Place of Injury building, etc. (S	pecify) y knowledge, deal	h occurred at the tim	ne, date and place,	City or Town,	use(s) and manner a	s stated.			
1/	To the Ho within 24 to To the Fu completely	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier Albut Rh	iner: On the basis of exa and manner stated.		29c. License	number	29	d. Date signed (Mon	th, Day, Year)			
	6		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	Print) VENVE B	ALTIMUME	= MARYL	AND 21:	13,2004			
	Sta Regist		31. Date filed (Month, Day, Year)	32 Medistrars	Signature								

		•	For Stata Registrar	State of I	Marylan		artment of I rtificate of				giene Reg. No.	200	act of	01138	
	Physici	an	1. Decedent's Name (First, Middle,		^ ·					2. Date of De Month	Day		ar	. Time of Death	
	/Media		Her		Scharp	er	45 05 7		-/ D*	JANUF				8:55 FM	
	Examin	er	4a. Facility Name (If not institution, Saint Josep	h Medica	1 Cer	nter	4b. City, Town, o		OWS				alti		
	Funeral Director		5. Social Security Number 213-16-6883	5. Sex 1) X M 2 □ F	Age (In yrs. 89	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da May 31	y, Year) 191	10	Country)	(State or Foreign	
			Usual Residence of Decedent		- 03					riay 31	, 1).		iui y ii	anu	
	arylan show	<u>_</u>	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							Inside City Limits 1 ☐ Yes 2 X No	
	189-1 s	ecto	Maryland Balti	more		Luthe	rville				10- 000				
	a or 2	ä	10e. Street and Number	May Ant (^_ 1		10f. Zip Code	0.2			-	zen of Wha	-		
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Вох	leath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			∃Ectopic pregnanc				2	3d. Date of	delivery		
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State of Mary	iano / Depai	ment of nea	ann and Men	tai mygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN **Physician** 2004 16 SOLOMON EDWARD 10:02 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth DEC 3 1905 **Funeral** 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MD Country) Months Days Hours Min 98 Yrs. Director 218-32-3225 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heatith and Mental Hyglene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State MD BALTIMORE 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exantiner must be indired at 10d. Inside City Limits Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 OLD COURT ROAD #413 21208 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** DRUG STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ HARRY STEIN REBECCA **SCHER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other traconce. 7-B PIPEHILL COURT BALTIMORE, MD. 21209 MRS. CYRILE GOREN/DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ANSPITED EXPLORATION CHAIM) CONGREGATION 1 □ XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 1/18/04 BALTIMORE,MD. _5 ☐ Other (Specify) Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician TNEYMONGA Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner sician and burlal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 4 Unknown 1 Yea Completed by page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2€ No 1 ☐ Yes 2 ☐ No funeral director, æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred - □ Natural 5 Pending 24 hours after death. 1 TYes 2 TNo investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled In by 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIVE 5905 CHUNCH LA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** -Month 2004 Shaw anuary 12 /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Age (In yrs. last birthday, If Under 24 Hrs. se 7. Age (In yrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Hours Min. 1 ☐ M 2 💢 F -26-7259 1931 NOTTH Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Middigal Examiner must be notified at 1 Yes 2 No Director Varyland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23s ve. permit. Pages 1 and 2 should be filed within 72 hours after deeth : Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "naturel", or Items 23. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 Donation 5 Other (Specify) son eny injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part1 shock Approximate Interval Between Onset and Death Coronary Immediate Cause (Final disease or condition resulting in death) Priysician 4 cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the line of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit the attending physicien and Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. E ☐Yes 2☑No 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No ၀ 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D13006 1113/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. REad St. 32. Registrar's Signature Thoma

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Dey, Year)

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ORIGINAL

(Sample)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10:15 P M 15 2004 Mary C. Strecker /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BROADMEAD RETIREMENT COMMUNITY Baltimore County Cockeysville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5,1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 92 Ohio June 099-26-6150 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "neturel", or itema 23e or 28a-f ahow Ite Madical Exeminer must be notified at 1 ☐ Yes 2 X No Director Cockeysville Maryland | Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 USA 13801 York Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 XXO
If Yes, Give
Year or Dates: 1 XNever Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Virginia State Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Health Department is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi Arthur Hayward Strecker Bertha May Cutter 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 sl nt of Health and : If item 27 is n 500 Chester Avenue, Annapolis, Maryland David W. Strecker (Pers. Rep) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury o Green Mount Crematory 1/17/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Services Ucersee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Martin D. Lawson 1 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause that in a ring Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed g physicien and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending for use as use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes After this certification, it the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dira npletely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatury and title of certifier 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) RD. COKESUL 31. Date filed (Month, Day, Year)
JAN 2 0 32. Registrar's Signature State 0 2004 Registrar TE COL

				artment of Health and rtificate of Death	Reg. i		
>	Physicia /Medic Examin Funeral Director	cal	Decedent's Name (First, Middle, Last) THOMAS BUCHANAN SCHIAFFINO 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	January 1	Oay Yeer 3. Time of Death 4c. County of Death	
			2737 Maryland Avenue, Apt 1 5. Social Security Number $215-22-3794$ 6. Sex 77 Age (In yrs. last birthday, 77 Yrs. 18 Security Number 77 Yrs. 19 Security Number 77 Yrs. 19 Security Number 77 Yrs. 19 Security Number 77 Yrs. 19 Security Number 77 Yrs. 19 Security Number 19 Secur	Baltimore City If Under 1 Year If Under 24 Hr. Months Days Hours Min	. (Month, Day, Yea	N/A 9. Birthplace (State or Foreign Country) Maryland	
Maryland 21215-0036	ne Maryland 8a-f show otified at	Director	Maryland N/A 10c. City. Town or L	Baltimore Cit		10d. Inside City Limits 1X Yes 2 □ No	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Itama 23e or 28e-f show aumatic event, the Medical Examinat must be notified at	To Be Completed by Funeral Dir	1 Never Married 2 Married 1 ☐ Yes 2 No	Under the state of the second		USA 14. Race - American Indian, Black, White, etc.	
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	Staqte of Maryland	
			17. Father's Náme (First, Middle, Last) Forturato Reggio Schiaffino	18. Mother's Na	me (First, Middle, Maide Kennedy Gam Jural Route Number, City	be1	
Baltimore, M	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Longwood Road, Bostion (Name of matory or other place)			
Baiti	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.					Home, Inc. Maryland 21212 Approximate	
of Vital Records, P.O. Box 68760,	ital or Attending Physician: The law requires that the death certificate be brafer death. ral biractor: After this certificate has been signed by the attending physicie led in by the funeral director, page 2 should be detached for use as the bur	Medical Certification; To Be Completed by Physician/Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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			Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting the significant conditions contributed to the significant conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions		23e. Did tobacco	use contribute to the cause of death?	
			ENCI-STAGE MEART FAILE DIABETES MEllitus 25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No	
			examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Hospital: 1 Inpatient 2 ER/Outpatier 2 8a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	Death (Check only one) Ing Home 9 Residence 6 □Other (Specify) 28d. Describe how injury occurred		
Division			4 Homiciae building, etc. (Specify)		City or Town, Sta	cation (Street and Number or Rural Route Number, ty or Town, State)	
7/			29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and or in and manner stated. 29b. Signature and title of certifier	estigation, in my opinion, death occi 29c. License number	urred at the time, date at	s) and manner as stated. Indiplace, and due to the cause(s) ate signed (Month, Day, Year)	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miguel Karacuschansky, M.D., 200 E 33rd Street, Baltimore, MD 21218						
#.	Sta Registr	te ar.	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Amend Item#2perPHYG828 2/20/04 EN Certificate of Death 2. Date of Death Jan 18 2004 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:32 P ^M Friedrich Wilhelm Tittel January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1**X** M 2 □ F 85 072-32-5640 1918 Bohemia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show Examiner hast be nutflied at 1 ☐ Yes 2X No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ō ā 1323 Windsor Ridge Lane 21401 Items 23a United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after a ment of Health and Mental Hygiene. ent: if item 27 is marked other than "netural", or flee ury or other than the Medical Examinatory or other traumatic event, the Medical Examinatory or other traumatic event, the Medical Examinating 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20XNo Specify: White Specify: þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ West Coast Professor University 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Friedrich Wilhelm Tittel Maria Notbursa Wana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanne Mons - Daughter 1323 Windsor Ridge Lane Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tment of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Importent: fi any injury o Balt. Wash. Crematory 1/22/04 Laurel, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Pah 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ance as **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sig 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
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2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel 29a. Certifier enifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edi | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) manner stated 29c. License number 057028 29b. Signat a title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) RIPGELY AVE STEZZI ANN APOLIS, MO, 21401 MP. 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 0 State 2004 Registrar

Tambering, Dominic Anthony
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	-	For Stete Registrar	State of Ma	iryianu / i		ficate of L		u Mem		1. No. 2 (004	01145
	_	1. Decedent's Name (First, Middle, La	st)						ate of Death	Day	Year,	3. Time of Death
Physicia /Medic		Dominic A.	Tamberino						01-	Day 13-	04	11:30 am
Examin		4a. Facility Name (If not institution, giv	e street and number)	d (4	b. City, Town, or	1 1	Death		4c. County		
		Franklin Square	Hospital	Center		Hose				Ba	/time	re
Funeral		5. Social Security Number 6. S	ex 7. Age ☑M 2☐F	(In yrs. last bir	N	f Under 1 Year Months Days	If Under 24 Hours	Min. (/	ate of Birth Month, Day, Y	(ear)		place (State or Foreign htry)
Director		212-74-4539	20.	48	Yrs.			Maı	2. 2,	1955	Mary	<i>r</i> land
and W	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	tion					1	Od. Inside City Limits
fanylan e bow	5	Maryland		Balti	imore							1X Yes 2 □ No
vith the Maryla t or 28a-f ehor be rotified at	Director	10e. Street and Number		Darca	шюте	10f. Zip Code			100	. Citizen of	What Cour	ntry?
death with the Maryland me 23a or 28a-f ehow mount be notified at		1312 Maple Avenu	ie			21220				Unite	√3 C+=	toc
death w	Funerai	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. Wa		spanic Origin	? (Specify	Yes or No-	14. Ra	ce - Americ	can Indian,
fter d	돌	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ N	No				ick, White,				
urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 1	Yes 21X No	Specify:			Specil	y: Wr	ite
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od wil	00	12			Stee	l Worker						reei
be lited within 7 ital Hygiene. Id other than "n	Be	17. Father's Name (First, Middle, Last							st, Middle, Ma	uden Sumai	me)	
	ပ္	Anthony Tamberir					Margar					0.41
d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)			Address (Street a						
and ealth m 27		Sonia Tamberino -	Wife	20b. Place o		aple Ave	enue E	Baltin Date	ore, M	lary1a: Oc. Location		
Fite or oth		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐	Removal from State	cemete	ry, crema	tory or other place				c. Location	- City of To	own, State
Pages ment of lant: If it		* 4 ☐ Donation 5 ☐ Other (Special	(y)	Balt.		. Cremat				aurel		
permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other tra		21. Signatur Funeral Service Lice	nosee that	MC1142	213	ame and Address 1 ey - Ash 4 Willow	is of Facility nton-Ma 7 Sprin	itthew	a Fune	ral H	ome Marv	Inc. Iand 21222
		23a Perty. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do								Approximate Interval Between
Dhysisian	4	Immediate Cause (Final	I / 2 L	o La L'a		ncreat						Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Me to (or as	a consequence		<u>Herear</u>	16 6	ullet	1			6 months
Examiner												
	ē	Saquer field y liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
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an an rial-tr	EX	resulting in death) Last	Due to (or as	a consequence	of):							
ficate be executed ficate be executed physician and "	edicai		_ d			<u></u>						
, to 100 mi		IF FEMALE:										
The law requires that the death certification is a second of the second	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	2 Fetal death		ctopic pregnancy					ate of delive	ery Day Year
e dea he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death	5 🗆 C	other (specify)						,
res that the de signed by the a	Phy	9 Unknown					on in Dort I		23a Did toba	CCO USA CON	tribute to ti	ne cause of death?
es the	þ	Part II. Other significant conditions		ut not resulting	iri (ne uriu	Briying cause give	alin Falti.		1 ☐ Yes			pably 4 □Unknown
w requir been si should	Completed	Benal insuffi	creisg					- 1	1 103	2,0,10	V	
elawi hasb	pie	G.I. Bleeding						_ '	24a. Was an autopsy		prior to co	psy findings available mpletion of cause of
The ate h	Son								performe I ☐ Yes 2]	200	death?	2 No
sian: artific ictor,	Be (25. Was case referred to medical examiner?				-		Death (Ch	eck only one)			
Physician: The la r this certificate has	၉	1 ☐ Yes 2 No	Hospital: 1 A Inpatie			3□ DOA Othe	4 🗀 (4015)		5 Residen			y)
ng P	ë.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. y Year)	Time of Injury	28c. Injury Work	(?		Describe how	r injury occui	rred	
eath.	cati	2 Accident Investigation 3 Suicide 6 Could not to					Yes 2 No		section (Stro	at and Mum	bar as Rus	J. Pauta Mumbas
or Att	Certification:	4 Homicide determined	28e. Place of Injuding, et	ury - At home, to c. (Specify)	arm, stree	t, factory, office			City or Town,		Der Or Mura	ul Route Number,
urs a urs a aral D		4570-441-0	businism Taska basa	-4 (re-evite de	a daath a		a data and s	alana and a	lue to the cou	100/0) and m		tatad
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director;	Medical		hysician: To the best miner: On the basis of and manner sta	examination ar								
ro th vithin ro th	Me	29b. Signature and title of certifier	•			29c. License	e number		290	d. Date signe	ed (Month,	Day, Year)
. , , , ,) () 2 kg	inse i	P		KF.S	DAA	00		1,131	1200	4 Md.21237
1)		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Pr	int)	^	\		D //		11/2.22
		Dr. Behzad Nas	seh Osko	uei 91	000	trankli.	n 59 u	arel)rive	Balt	inore,	Md. 21231
⇒ Sta	ite	31. Date filed (Month, Day, Year)	Ef.	ar's Signature	1	10	C				/	
Registi	ar	JAN 2 0 2	304 R. Jean	en to	A NO							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Ragistrar	Sta	ate of Ma	ryland				ealth a Death	nd Me	ntal Hy	giene Reg. No	/		01146
- 1	Physi	cian	Decedent's Name (First, Middle Anna Mae Tole	_								Date of Do Januai		ž, 20°0		Time of Death
	/Med	lical	Anna Mae Tole 4a. Facility Name (If not institution		and number)			4h City	Town or	Location of		Januar		. County of De		12:40 p ^M
	Exam	iner	Stella Maris	givo olivooi	and mannedly					Valle			1	Baltimo	re	
	Funera	al	5. Social Security Number	6. Sex		(In yrs. las		Il Under Months		If Under 2 Hours		Date of Bi (Month, Di an. 2	rth ay, Year)	9. E	irthplace Country)	(State or Foreign
	Directo	r	232–05–5377	1□M 2	2CXF	83	Yrs.				J	an. 2	1,19	20 Wes	st Vi	irginia
	and		Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Lor	cation							10d.	Inside City Limits
	Mary -f sh	to	Maryland Baltin	ore		Nott	ingha	m								1 ☐ Yes 2 127No
	th the	lrec	10e. Street and Number					10f. Zip					_	tizen of What	Country	}
	death with the Maryland ims 23a or 28e-f show r must be rediffed at	Funeral Director	4528 Wishal Driv				-1		236–				U.S			
E (er de: Items	une	11. Marital Status	Ar	as Decedent E med Forces? ☐ Yes 2 XNo		13. V	Vas Deced Yes, spec	lent of Hi cify Cuba	ispanic Orig n, Mexican,	jin? (Speci , Puerto Ri	fy Yes or N can, etc.)	0-	14. Race - Ar Black, W		indian,
P.	urs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	lf '	Yes, Give ear or Dates:	,	1	☐ Yes	No K	Specify:				Specify:	Wh:	ite
12:40 p.	72 hours after natural', or Ite	Completed	15. Deceden	's Education) inleted)		16a. Deced	ent's Usua	al Occupa	ation	of working	,	16b. K	ind of Busines	ss/Indust	try
12:	within ene. then	nple	Elementary/Secondary (0-12)	T	ollege (1-4or 5+	·) I	lite. C Tomema		se retired	during most ()			OW	n Home		
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2004	d be f antal h	To Be	Frank Gregoria									Char		,		
2	should and Men marke	F	19a. Informant's Name/Relations		rint)		19b. Mailin	g Address	(Street	and Numbe	r or Rural i	Route Numi	oer, City	or Town, State	, Zip Co	de)
15,	and 2 alth a 27 l		Paula Toledo Mi	ller (Daughte	er)	4528	Wisha	al D	rive,	Nott	ingha	m, Ma	aryland	21.	236–3821
ANUARY 1	of He		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Remov	al from State	cen	ce of Dispos netery, cren	natory or o	ther plac	, ,	Da			ocation - City		
UAE	Pages tment of lent: If its		`4 □Donation 5 □ Other (S	pacify)		Sacı									_	aryland
JANUARY	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Marel Hygiene. The filed filed within 72 hours atter death with the Marylan Important: If them 271s marked other than "natural; or Items 23a or 28e-1 show any injury or other traumatic event, the Madical Examinar must be natified at	- Duce	21. Signature of Puner of Service	Licentide			22	. Name an		ruzdz.	inski	Fune:	ral 1	Home, I	A.	and 21221
· 1			23a. Part / Enter the disease, or shock, or heart failure. List	complication	ns that caused t	the death.	Do not ente							SCA, MC	An	proximate erval Between
	Physicia	0	Immediate Cause (Final disease or condition		CONGEST:										Ör	nset and Death
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0200	ysicie			d												
4	ng ph	Physician/Medical	IF FEMALE:	1		-							1			
	Boath certifica attending ph	lan/I	23b. Was decedent pregnant in the past 12 months?	1	yes, outcome o	2 ☐ Fetal d	leath 3□	Ectopic pi						23d. Date of o Month	delivery Da	y Year
-	the de	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		Pregnant at t Unknown	ilme or dea	itn 5∟	Other (sp	меспу) <u> </u>							
9 6	v requires that the d been signed by the should be detached		Part II. Other significant condition	ons contribu	ting to death bu	t not result	ting in the ur	nderlying o	ause giv	en in Part I.		23e. Did	tobacco	use contribute	to the c	ause of death?
TOLEDO	law requires as been signi	ed by				***						1□	Yes 2	□No 3□	Probabl	y 4 🛣 Unknown
10	law reads says been as been 2 sho	Completed										24a. Wa	s an	24b. Were	autopsy	findings available etion of cause of
田 (E										peri 1 ☐ Yes	ormed?	death	? es 2[
	vital r sician: Th certificate irector, pag	Be	25. Was case referred to medica examiner?		tal.				0.15		of Death (Check only	one)			
	this aldi	2	1 ☐ Yes 2 📉 No 27. Manner of Death	Hospit	1 Unpatier		R/Outpatien 28b. Time of			4 🗀 1901				6	oecify)	HOSPICE
V ;	_ 5 <u>9</u> 8	tion	1 Natural 5 Pendir 2 Accident investi	9	la. Date of Injury (Month, Day	Year)	Injury	M	8c. Injur Wor	k?" Yes 2⊟t		d. Describe	TIOW III	ny occurred		
•	lor Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could 4 Homicide determ	not be	Be. Place of Inju	ry - At hom	ne, farm, str	eet, factor	y, office		28	I. Location City or To		nd Number or	Rural R	oute Number,
č	telor s afte al Dire	Certification:	4 - Nomicide		building, etc.	. (Эреспу)						Ony or re	JWII, Olai			
6	To the Hoepitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		Examiner: (n: To the best of On the basis of and manner stat	examination										
1	To the within 2 To the comple	Med	29b. Signature and title of pertifie		and manner star	190.		290	c. Licens	e number			29d. Da	ate signed (Mo	onth, Day	/, Year)
	8		•	11	_				DY	372	5-			1/16	10	4
	5		30. Name and address of person	who comple	ited cause of de	eath (Item 2	23а) (Туре,	Print)	-					//	/	-
			DR. TARIQ MAR		2300 D			LEY F	D.	TIMON	IIUM,	MD 21	093			
		State	31. Date liled (Month, Day, Year)	0 0 200	32. Hegistra	u s aignatu المسائلة	15.	6004								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene... Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Paul Tomblin 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KOSE dale MO/P 5. Social Security Number 7. Age (In yrs. last bi Birthplace (State or Foreign Country) **Funeral** Days Hours 234 44 4821 73 Yrs. 1930 West Virginia Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show It e Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 341 Homberg Avenue 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Korean Specify: White ۵ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) Steel Worker Beth. Steel Corp. permit. Pages 1 and 2 should be fife.
Department of Health and Mental Hy, important: If item 27 is merked other any injury or other transment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leondas Tomblin Bernice Watson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 "G" Church Hill Road Bel Air Md 21014 (friend) Melanie Meade 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Holly Hill Mem Gardens 1/16/04 Baltimore County Md. 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex MAryland 21221 Enter the disease, or complications the Daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐Unknown 1 Tyes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, f Be 25. Was case referred to medical 26. Place of Death (Check only one) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who complete

ONA NOVELLO

31. Date liled (Month, Day, Year)

9000 Franklin

SHARD Drive Bactimore

cause of death (Item 23a) (Type, Print)

U

سي		State Registrar 1. Decedent's Name (First, Middle,	Last)	- Ce	rtificate of D		Reg. I		3. Time of Death
Physici /Medic		Rosemary Ta	wney				Month January	15, 2004	4:30 P.
Examir		4e. Facility Name (If not institution,			4b. City, Town, or L			4c. County of Dee	
		2427 Golupski		(In use lock high day	Esse:	X If Under 24 Hrs. 8	Date of Birth	Baltimo	
Funeral Director		5. Social Security Number 219-10-5662 Usual Residence of Decedent	6. Sex 7. Age 1	(In yrs. last birthday 77 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yearch 27,	1926 M	hplace (State or Fore buntry) D
ied at	tor	MD 10b. County Balti		10c. City, Town or L	ocation Essex				10d. Inside City Lin 1 ☐ Yes 💥
3a or 28a M De noti	al Director	10e. Street and Number 2427 Golupski	Road		10f. Zip Code 2122	1	10g.	Citizen of What Co	ountry?
Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinational Le molified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? od 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Specif , Mexican, Puerto Ric Specity:	y Yes or No- an, etc.)	14. Race - Ame Black, Whi Specify: W	
n "natu Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5+	(Give	edent's Usual Occupati e kind of work done du DO NOT use retired)	ion iring most of working	16b	. Kind of Business	/Industry
giene or tha	E O	12			nistrative			Textile)
d oth	Be	17. Father's Name (First, Middle, L	ast)		1	18. Mother's Name (F	First, Middle, Maid	len Sumame)	
s marke	ဥ	Thomas Edward W. 19a. Informant's Name/Relationsh		19b. Mail	ing Address (Street an	Mary Fra nd Number or Rural F			Zip Code)
alth a 727 is er tra		Lynn Street/Dau	ghter	1907	Tadcaster		imore,		
of He If item or oth		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date	200.	. Location - City or	Town, State
ment lant:		`4 □ Donation 5 □ Other (Sp	ecify)		n Mem. Gard				
Departi importi eny inj once.		21. Signature of Fineral Services	icensee	S	22. Name and Address terling Asl 36 Edmonds	of Facility hton Schwa on Ave. Ba	b Funera	al Home, MD 2122	Inc.
4		27a. Pan1. En or the disease, or disease, or disease, or head failure. List of Immediate Cause (Final	complications that caused to only one cause on each line	he death. Do not er	nter the mode of dying,	, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Deat
hysician Medical xaminer		disease or condition resulting in death)		consequence of):	lin cano	~			1 well
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dea to (or se a	echeaquenes of):					
attending physician and for use as the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
ther death. Director: After this certificate has been signed by the atlending phy in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t	Petal death 3	□Ectopic pregnancy			23d. Date of de Month	livery Day Year
igned by the atte	Phys	9 Unknown Part II. Other significant conditio		t not resulting in the	underlying cause giver	n in Part I.	23e. Did tobacc	co use contribute t	o the cause of death
been signed should be del							1 ☐ Yes	2√2No 3□P	robably 4 Unkn
cate has be	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 ☐	? prior to death?	utopsy findings avail completion of cause 2 2 3 No
ils certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death (0 Flotter (0-	
fter this	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		of 28c. Injury : Work?	at 28	d. Describe how in		icity)
	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ot be 380 Block of Injur	ry - At home, farm, s (Specify)		es 2 No	Location (Street City or Town, St		ural Route Number,
24 hours a Funeral etely filled	edical C		g Physicien: To the best of examiner: On the basis of and manner stat	examination and/or					
no and	M	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mon	th, Day, Year)
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\$ \$ £ 8		30. Nam a d address of person			Orien)	mklin Sju		. 0	

4	Aaron 'I	no	mas 1 - For State Registrar	State of Maryland / D	epartment of Healtl Certificate of Dea		ygiene 2004	0 1130				
		36	Decedent's Name (First, Middle, Last,			2. Date of D	eath	3. Time of Death				
	Physici /Medi		ACRON	7	THOMAS	Janua:	ry 13 2004	810 a M				
	Examir		4a. Facility Name (If not institution, give University Hospit	-	4b. City, Town, or Locati Baltimore		4c. County of Death	Δ				
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. last birth		der 24 Hrs. 8. Date of B	irth 9. Birth	place (State or Foreign				
	Director		016-04-06-00	M 20F 54 Y	rs. Months Days Hou	MARCH	26,1949 MA	RYLAND				
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits				
	Mary a-f eh	tor	MARVIAND N	1A	BALTI	HORE C	ITV	1⊠Yes 2□No				
	or 28	Jirec	10e. Street and Number	4	10f. Zip Code		10g./Citizen of What Cou	ntry?				
	s 23e	ral	1813 ARUN	AH AVENUE	2	1217	USA	. a				
	fter de ritem	Fune	11. Marital Status 1 ☐ Never Married 2 🛱 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	origin? (Specify Yes of Nican, Puerto Rican, etc.)	lo- 14. Race - Ameri Black, White,					
93	ral', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Spec	cify:	Specify: BL	ACK				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, If a Muclical Energies must be notified at ances.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	cation 16a. (Decedent's Usual Occupation (Give kind of work done during ri life. DO NOT use retired)	nost of working	16b. Kind of Business/In	dustry				
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d 2	a filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)			other's Name (First, Middle		TON CO,				
/lar	should be and Mental s marked o umatic eve	To B	JA	BEN	E	LAINE	E. 7	HOMAS				
Jan	2 sho		19a. Informant's Name/Relationship (Ty	/	Mailing Address (Street and Nu	- 1	- 29					
	1 and Health em 27 ther tr		VIVIAN THO MA. 20a. Method of Disposition		Disposition (Name of	LETON ST.	20c. Location · City r To	40 21201				
nor	Pages nent of I int: If it		1 Burial 2 Cremation 3 □F 4 □Donation 5 □Other (Specify)	emoval from State cemetery	, crematory or other place)			1				
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		ME MORIAL PARK 22 Name and Addrass of Fa	igility Beauty	TR FUNER	AL HOME				
Ö	Depa Impo any ir	1 0		1101	22. Name and Address of Fa	-ULTON AV	E. BALTO. M	0.21217				
į.			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not be cause on each line.	ot enter the mode of dying, such			Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		14 Juries			Onset and Death				
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Ø	ifficate g phys	edical										
Вох	eath certific attending p	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 Ectopic pregnancy		23d. Date of delive	*				
o.	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year				
۵.	that the de led by the a detached t	y Ph	Part II. Other significant conditions con	atributing to death but not resulting in	the underlying cause given in Pa	art I. 23e. Did	tobacco use contribute to the	ne cause of death?				
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<u> </u>	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	Other	ace of Death (Check only						
Division of Vital	9 Physics or this seral direction	\vdash	27. Manner of Death	28a. Date of Injury 28b. Tir	me of A 28c. Injury at		idence 6 Other (Specify how injury occurred	y)				
ion	ttending F death. stor: After the funer	atlo	1 Natural 5 Pending 2 Accident Investigation	11304 7:4		ONO Subject	fell down an el	evertor shaft				
N N	el or Attendi s after death of Director: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (City or To	(Street and Number or Rura wn, State)	I Route Number				
	spitel cours at nevel D		29a, Certifier 1 ☐ Certifying Phys		struction buildi		toward street,					
V	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only one)	sician: To the best of my knowledge, ter: On the basis of examination and/ and manner stated.	or investigation, in my opinion, o	and place, and due to the death occurred at the time,	date and place, and due to	ated. the cause(s)				
	To th withir To th comp	Me	29b. Signature and title of certifier	100	29c. License numbe	ər	29d. Date signed (Month,	Day, Year)				
,	*		Zabiruo	2 11	OCME		January 14 2	2004				
	1,5		30. Name and address of person who co			Street, Balt	imore, Maryla	and 21201				
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2004	32. Registrar's Signature	Sporks							

		-	For State Registrar	State of Maryland	•	artment of H tificate of			Reg. No. 20	04 01150
	Physicia /Medic		1. Decedent's Name (First, Middle, Last MARY TOR	nollen				2. Date of De. Month JANUAR	7 18 2	Year 2:13 p M
•	Examin	er	11111	SPITALCENTER		4b. City, Town, C	ALTIMO	RE	4c. County o	'A
	Funeral Director	1	5. Social Security Number 215-12-4127 Usual Residence of Decedent	7, Age (<i>lin yr</i> s. <i>las</i>	Yrs.	If Under 1 Year Months Days		Ain. 8. Date of Bin (Month, Da July 26	y, Year) 5, 1919	9. Birthplace (State or Foreign Country) Maryland
	Maryland f show	ior	10a. State 10b. County Maryland N/A		Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the 1 3e or 28e- It be notifi	Direc	10e. Street and Number 3700 St. Vict	or St.,		10f. Zip Code	21225		10g. Citizen of W	hat Country?
36	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Mydical Exercit at most be notified at	by Funeral	11. Marital Status 1 ☐ Nøver Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub		? (Specify Yes or No uerto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
21215-0036	filed within 72 hou Hygiene. ther then "neture int. the Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of d)	working		iness/Industry e City Board lucation
Maryland 2	be de la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Last)	errare			18. Mother's Mary	Name (First, Middle, Kuffel	Maiden Sumame)
	カニトラ		19a. Informant's Name/Relationship (7 Edward F. Tormoll			-		r Rural Route Number St., Balto	., Md. 2	1225
Baltimore,	Pages 1 and nent of Healt set: If item 2 arry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	netery, crei	osition (Name of matory or other pla Crematory	, Inc.	Date 1/20/04		city or Town, State re, Maryland
Balti	permit. Pages Department of Importent: If i eny injury or once.		21. Signature Funeral Service Licen	see Kevin E Ecke	er g	Name and Addr ACCUITY-F 237 E. Pa	olyniak tapsco	Funeral Ave., Bal	Home, P.	A 21225-1856
1	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. A CUTE	Do not ent	ter the mode of dyi	ng, such as car		rrest,	Approximate Interval Between Onset and Death 6 Hores
	/Medical Examiner	ier	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque						
,092	e be executed sician and e burial-transit	icai Examiner	cause. Enter Indentying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):				=	
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3[⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	ey		23d. Date Mon	o of delivery th Day Year
	uires that I signed by Id be deta	Ď	Part II. Other significant conditions of SEVERE LA	ontributing to death but not result		ınd <i>e</i> rlying cause gi	ven in Part I.	23e. Did 1	_/	bute to the cause of death? 3 Probably 4 Unknown
Records,	The law req te has beer age 2 shou	Completed						24a. Was auto perfo	ormed?// de	lere autopsy findings available rior to completion of cause of eath? Yes 2 No
ital	stiffica ctor, p	BeC	25. Was case eferred to medical examined?					Death (Check only		
Division of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	ို	1 Ses 2 No 27. Manner of Death 1 Autural 5 Pending	28a. Date of Injury (Month, Day Year)	R/Outpatie 28b. Time o Injury	of 28c. Inju			dence 6 Othe	(-777
Divisio	if or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		ne, farm, st	reet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	or or Rural Route Number,
4	e Hospite 124 hours e Funerel letely filler	Medical C	29a. Certifier 1 ertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know niner: On the basis of examination and manner stated.	rledge, dear on and/or ir	th occurred at the the threating the threating at threating at the threating at the threatin	ime, date and p opinion, death	place, and due to the occurred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	_	Me	29b. Signature and title of certifier		M	- III - /	Se number	73		(Month, Day, Year) 18 2004
	10		30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)				40 21237
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Jre Ro	8				

1 Consider of New France (North Acad) House of the statistics of the statistic				For State	State of Marylar					_	2001	01151
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## Feature for entertied goes to the enterti		Physici	an		۸ ٦	and .			Month	Da	y Year	
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The content of the		Funeral				last birthday		If Under 24	Hrs. 8. Date of Bir	th		
Usual Procedure of December 100 County					M 2DE		Months Days	Hours	Min. (Month, Da	y, Year)		
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The companies of the control of th		er de	nne		Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origi an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	-		
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Compared to the compared to	Σ	alth a		Mr Gerald L. Smith	/Step-Son	15011	Whippoorwil	1 Road,	Nokesville,	Virg	inia, 2018	1
Compared to the compared to	ē.	of He item		·		Place of Disponentery, cre	osition (Name of	(e)	Date	20c. Lo	ocation - City or T	own, State
Compared to the compared to	Ĕ	Page nent of nry or							an 13,2004	Smi	thsburg,	Maryland
Compared to the compared to	三	mit. partmoorte		21. Signature of Funeral Service License			2. Name and Addres	s of Facility	-,			,
Tripsistron Medical Examiner	œ	88 1 2 8		J. Kijan 71	1= Millian	110	Keeney &	Basto	rd P.A. Fu	nera	al Home	1 1 0170
Was decoded treganal to the past 12 months? 23d. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 24d. Was an autopay Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Quinknown 24d. Was an autopay Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Quinknown 24d. Was an autopay Part II. 25d. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Quinknown 24d. Was an autopay Part II. 25d. Was case referred to medical examiner? 25d. Was case referred to medical examiner? 25d. Was case referred to medical examiner? 25d. Very 25d. No 25d.		/Medical Examiner	Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	erotic uence of): wence of):						Interval Between
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29a. Certifier (Check only one) 29m Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and didness of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, Jr, M.D., 15 West Seventh Street, Frederick, Maryland 21701 State 29a. Certifier (Check only one) 29d. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D35164 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, Jr, M.D., 15 West Seventh Street, Frederick, Maryland 21701	g	ificat or, pa		25 Was case referred to medical				OC Disease		-4-	1 ∐ Yes	2 □ No
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Andrew Zarick, Jr, M.D., 15 West Seventh Street, Frederick, Maryland 21701 State 31. Date filed (Month, Day Jew 1 7 2002 Hegister's Signature		V		30. Name and address of person who con	npleted cause of death (Item	n 23a) (Type.	Print)					
State 31. Date filed (Month, Day Yew) 1 7 2009. Hegister's Signature		0						eet. F	rederick	Mars	rland 21	701
		Sta Registr		31. Date filed (Month, Day Yew 1 7	7 (132. Registrer's Signa	ture 🚛	Bosto	7				

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	Phys t :i		1. Decedent's Name (First, Middle, La Stephen	tay lor	_			2. Date of Deat Month	Day Yes	3. Time of Death	
	Examin		4a. Facility Name (If not institution, giv	e street and number)	enter	4b. City, Town, or	Location of Death	1	4c. County of D Batter	eath	
	Funeral Director		212-76-6633	ex 7. Age (In ya	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec.12,		Birthplace (State or Foreign Country) Maryland	
	faryland	or	Usual Residence of Decedent 10a. State 10b. County MD Baltim		City, Town or Lo			1,		10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	or 28a-	Jirect	10e. Street and Number	1010	5021195	10f. Zip Code		1	0g. Citizen of What	Country?	
36	hin 72 hours after death with the Maryland e. sn "neturel", or Hems 23a or 28a-f show Medical Examener must be incitiled at	by Funeral Director	Turner Bld. @ F 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Rosewood Cente 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Z1117 Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No		pecify Yes or No- Rican, etc.)		States merican Indian, thite, etc. White	
21215-0036	d within 72 hou giene. er then "naturi the Medical E	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa o kind of work done di DO NOT use retired) Disabled	uring most of world	xing	16b. Kind of Busine	b. Kind of Business/Industry	
	id be file enta! Hyg ked othe ic svent,	To Be C	17. Father's Name (First, Middle, Last Malcolm Taylor)			18. Mother's Nam Elizat	ne (First, Middle, M neth Pi	Maiden Sumame) litt		
Maryland	d 2 shou th and M 7 Is mar traumati	-	19a. Informant's Name/Relationship (Malcolm Taylor/f			ng Address (Street a	nd Number or Ru	ral Route Number	City or Town, State		
	Pages 1 am nent of Heall int: If item 2 iry or other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	201	. Place of Dispo	osition (Name of matory or other place			20c. Location - City	or Town, State	
Baltimore	permit. Par Departmen Important: sny injury.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral hervice Licer		2	alley Mem. 2. Name and Addres: 1050 York	s of Facility Ru		on Funera	, Maryland 1 Home, Inc. 21204	
U a	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	polications that caused the done cause on each line.	eath. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death A CLOU S	
8760,	/Medical Examiner physicien and the burial-transit	lical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons Due to (or as a cons C. Due to (or as a cons Due to (or as a cons Due to (or as a cons	sequence of): Sequence of): Weight	Acut	En who	e perf bod tarde	oration of	S COURT EXAMINER IN	
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)		Heri	o 23d. Date of Month	delivery Day Year	
S,	quires that the signed by ald be detact	b	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause give	n in Part I.			e to the cause of death? Probably 4 Dunknown	
I Record	. The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was a autops perform	y prior ned? death		
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	! ☐ ER/Outpatie	nt 3 DOA Othe		th (Check only on	e) ence 6 □Other (S	Specify)	
Division of	fter	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not betermined	28e. Place of Injury - A	t home, farm, st	Work	?	Subject	w injury occurred	Run Joute Number,	
Ο̈́	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo		4 nomicide	building, etc. (Spe	unk	Chain		City or Towr	UNKnow		
	the Hos iin 24 ho the Fun pletely f	ledical	(Check only 2 Medicel Exer	hysician: To the best of my liminer: On the basis of exam and manner stated.	ination and/or in	ivestigation, in my op	inion, death occur	red at the time, d	ate and place, and	due to the cause(s)	
)	Viith To To	Σ	29b. Signature and title of certifier	arpa ws		29c, License	621	8 2	9d. Date signed (M	onth, Day, Year)	
	2		30. Name and address of person who Jay Karpa 1700	completed cause of death (I			Pikesvill	.e, MD	21208		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** aua 7:00 M 3 200 banuar len /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Greater Towsor ente If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. NØM 2□F VONP Director January an Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or items 23s or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SA *a*1aa 1206 a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Intant 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vaua 2 ames 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Nul)ber or Rural Rouls Number, CHILCOAT 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 Removal from State ¹ 4 ☐ Donation 5 Other (Specify) 21. Signate Address of Facility Approximate Interval Between 23a. Part1. Enter the disease, or com shock, or heart failure. List only , or complications that caused the death. Do not enter the mode of dying, ist only one cause on each line. such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician hr. 7 mir /Medical **Examiner** 18 minutes ntanea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physiclan/Medical IF FEMALE If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 DEctoric pregnancy 2 Eetal death 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown n in Part I. Par 23e. Did tobacco use contribute to the cause of death? 5 otein 3 Probably 24a. Was an 24b. Were autopsy findings available

or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for t Certification; To Hospitel

25.

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till. Other significant cond				
JEVA TEOT	natel a	SE101/1	arpna	10001
Was case referred to med	ical			

		performed?	death?
Was case referred to medical	26. Place of Death (C	Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
Manner of Death 1 □ Natural 5 □ Pending investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work?	d. Describe how inju	

27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. injury at Work? 1 □ Yes	2 □ No	28d. Describe how injury occurred
3 🗌 Suicide 4 🗎 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street,	factory	, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.		12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	(Check only one)	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	01107	and mainer stated.

(Check only one)			is of examination and/or investig	ation, in my opinion, death occurred at the tim	
29b. Signature and	d title of centiler	11		29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Truson MD 2116

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 2 0 2004 32. Registrar's Signature

Mackey

the

4-00274 KD		Please T		nd / Depa	delible Ink. Ensure A artment of Health and rtificate of Death	Mental Hyg	iene
Physi	ician	Registrar 1. Decedent's Name (First, Middle, Last)		Ce	Tillicate of Death	2. Date of Deat Month	h Day Year 3. Time of Death
	dical	ARTHUR G. VAN			45 Oh T	JANUARY	10,2004 11:07P. M
Exam	niner	4a. Fecility Name (If not institution, give :		רוידונות איידור	4b. City, Town, or Location of Deat	n	N/A
Funera	al	JOHNS HOPKINS BAYV 5. Social Security Number 6. Sex	7. Age (In yrs	Last birthday)	BALTIMORE If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
Directo		212-58-6412 15 Usual Residence of Decedent	1M 2□F 5	1 Yrs.	Months Days Hours Min.	2/13 ^{Day}	MARYLAND
nylan how	_	10a. State 10b. County		ity, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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r dea	Funeral	Tr. Marital States	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
hours after hural; or its	by Fu	1 ☐ Never Ma <i>rri</i> ed 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X3 Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No Specify:		Specify: WHITE
thin 72 hours aff e. an *natural*, or	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupation	4.1	16b. Kind of Business/Industry
within 72 ene. than nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) Coltege (1-4or 5+)		kind of work done during most of wo DO NOT use retired)	rking	
2 0 0 -	Con	10	0	SAI	LESMAN		SELF EMPLOYED
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should not Men marke umatic	10	19a. Informant's Name/Relationship (Ty		10h Maili	ng Address (Street and Number or Re		City or Town State Zin Codel
Ma d d d d d d d d d d d d d d d d d d d		DIANE FREELAND		1			ORE MD. 21222
s 1 and f Healt item 2		20a. Method of Disposition		Place of Dispo	osition (Name of	The second secon	20c. Location - City or Town, State
3 0 °		1 🖾 Burial 2 □ Cremation 3 □ R *4 □ Donation 5 □ Other (Specify)	lemoval from State HO	ĽĽŸ Ĥ	TLL MEM. 1/1	9/04	MIDDLE RIVER, MD.
permit. Pages 1 ar Department of Hes Important: If item any injury or othe	혏	21. Signeture of Funeral Service License	99	K ²	ACZORÓWSK F ^{acili} FUN	ERAL HO	ME P.A.
	a	23a. Pert1. Enter the disease, or compli		1	201 DUNDALK AV	E. BALT	IMORE, MD. 21222
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S, F, Fres that igned b	oy P	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying cause given in Part I.		pacco use contribute to the cause of death?
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ysician: The ysician: The is certificate his director, page	Be	25. Was case referred to medical examiner?				ath (Check only on	θ)
5 £ 5 8	2	27. Manner of Death	1 □ Inpatient 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		,	ence 6 Other (Specify) ow injury occurred
UNISION OI To the Hospitel or Attending Phy. within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st		28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
e Hospite 24 hours e Funera letely fille	Medical C				h occurred at the time, date and place evestigation, in my opinion, death occurred		ause(s) and manner as stated. ate and place, and due to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier			29c. License number	25	9d. Date signed (Month, Day, Year)
		YA	I'ms mary	GRIPRE	O.C.M.E.	JA	ANUARY 11,2004
		30. Name and add of s of perion who co	omple ed cause of death (ite	em 23a) (Type	Print)		
			NITA KORKLE			Baltimor	re, Maryland 21201
	State istrar	31. Date filled (Month, Day, Year) JAN 2 0 200	32. Registrar's Sign	- Ag	Acres 21		
		0 440	9 18,7	1000	19 201 1 Carl Ac 18 1		

ORIGINAL

Description 13 Aprental

			For State Registrar	State of Ma	•	epartment of H Certificate of I			2004	01155
	Discolati		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		WILLIAM ED	WARD WAT	ERS			JAN.	14 2004	1215 PM
	Examin		4a. Facility Name (If not institution, give		0 4	4b. City, Town, or	Location of Death		4c. County of Deat	
			MARINEL HEAT		Selair		If Under 24 Hrs.	9 Date of Birth	HARRO	
	Funeral		5. Social Security Number 6. Security Number 12	M 2□F	(In yrs. last birtho 74	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y JAN 15,	(ear) Co	hplace (State or Foreign untry)
	Director		212-26-5549 Usual Residence of Decedent		74			JUAN. 13,	1929 MAN	YLAND
	ylanc how		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Ma	cto	MARYLAND HARFOR	RD CO	J	OPPA				1 ☐ Yes 2 X No
	हैं। 97.28	Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	untry?
	ath w	ia.	213 PHILADELPHI		5i. 11.0	210		anif . Van as Na	U.S.A.	doon Indian
	er de	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces?	lo.	 Was Decedent of H If Yes, specify Cuba 	in, Mexican, Puerto	Rican, etc.)	Black, White	
3	irs aft	by F	3 Widowed 4XXX Divorced	1 X Yes 2 ☐ 1 If Yes, Give Year or Dates:	51/54	1 ☐ Yes 2X No	Specify:		Specify: BLA	CK
2	2 hou	ted	15. Decedent's Edu		16a. Do	ecedent's Usual Occup	ation	16	b. Kind of Business/	Industry
7	e. e. n	Completed	(Specify only highest grad	College (1-4or 5	- In	fe. DO NOT use retired		(III)		
V	od wil	Co	7th grade		TR	ACKMAN			RAILROAD	
Maryland Z1Z13-0036	be filed within 72 hours after death with the Maryland ltal Hygiene. d other than "natural", or Itams 23a or 28a-f show avant, I'm Medical Examinan must be notified at	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	uiden Sumame)	
<u> </u>	ould Men Marke hatic	은	BILL LOWERY	0-1-11	40) 1	1 W - 1 dd (Ch)		N WATERS	Ditto and Travello Change C	Y's Control
2	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Ty			lailing Address (Street				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is merked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic event, Ita Medical Examinat must be notified at ance.		Helen Demby/Frier	ıd	20b. Place of D	3 Philadel; isposition (Name of			lary Land 2 oc. Location - City or	
٥	nt of nt of t: If it		1 ☐ Burial 2 🎞 remation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		crematory or other plac		C 0.4 D.	TELMODE	MADAK TAND
altimore,	artme ortani injury		21. Signature of Funeral Service Licens	99 7		CREMATORY 22. Name and Addre			ALTIMORE,	
ğ	Depar Impo		Charles &	1 Jou	ver	wm c BROWN 321 S PHIL	ADELPHIA	BLVD, ABE	ERDEEN, MD	21001
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused ne cause on each lin	the death. Do not ne.	enter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Ohset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a. Pin	Tumon.)a				1WILK
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)	•				
		<u>-</u>		Due to (or as	a consequence of)					
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Dispace or injury that initiated events							
<u></u>	execting and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequence of)					
8/60,	death certificate be executed e attending physician and nd for use as the burial-transit	dicai		d						
Q	death certifica attending pt d for use as t	Med	IF FEMALE:	222 11						
ROX	ath ca	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
j.	that the de ed by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time or death	5 ☐ Other (specify)				
1	that the ed by th detache	h h	Part II. Other significant conditions co	ntributing to death b	ut not resulting in th	ne underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	requires t een signe	d by						1 Yes	2 □ No 3 □ Pr	obably 4 Dunknown
် ပ	> 0 0	Completed						24a. Was an	24b. Were au	itopsy findings available
e T	o - g	mo						autopsy performs	d? death?	completion of cause of 2 No
g	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only one)		2010
		To B	examiner?	Hospital:	ent 2 ER/Outp	atient 3 DOA Oth	er: 4 V Nursing H	ome 5 Residen	ce 6 □Other (Spe	cify)
Division of	ding Phys		27. Magner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Tin y Year) Inju	ıry Wor	y at k? Yes 2 □ No	28d. Describe how	injury occurred	
NISK	r Attending ter death. rector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj		, street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
0	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier f Certifying Phy	sician: To the best	of my knowledge.	death occurred at the tir	ne, date and place	, and due to the cau	se(s) and manner as	stated.
U	ths Hos nin 24 h the Fur npletely	edical	(Check only 2 Medical Exami	iner: On the basis o and manner st	examination and/	or investigation, in my o	pinion, death occur	rred at the time, date	e and place, and due	to the cause(s)
	To the Comp	Ž	29b. Signature and title of certifier	444		29c. Licens	e number	290	d. Date signed (Mont	h, Day, Year)
	1		> XI- /	かり		1 23	xGTL	Vy	munry 14	2004
	U		30. Name and address of person who co	completed cause of c	leath (Item 23a) (Ty	ribbt	3, 100	Mary)	Del 210	114
ľ	Sta Regist	ate rar	31. Date filed (MoJANY, 200) 20	32 Registr	ar's Signature	Growth &				,

			For State Registrar	State of Maryla		artment of H			ene g. No. 2011	. 01156
	Physicia /Medic		Decedent's Name (First, Middle, Last)	Doris	Wil	burn		2. Date of Death Month		3. Time of Death 5:25/TM
	Examin	er	4a. Facility Name (If not institution, give s 5	JUNSING CA	enter s. last birthday)	4b. City, Town, or If Under 1 Year Months Days	Location of Deat Scale Till If Under 24 Hrs Hours Min.	nore	4c. County of Deatl 4c. Pearl 9. Birth Yearl	n nplace (State or Foreign untry)
	Director		215-09-5525	M 212 F	85 Yrs.	Worth's Days	Tiodis Iviii.	Dec. 31,	,1918 Mary	yland
	Maryland	tor	10a. State 10b. County Maryland Carroll	10c. C	City, Town or Lo Westmi					10d. Inside City Limits 1 ☐ Yes 2,☐ No
	with the	Directo	10e. Street and Number	11.1.00		10f. Zip Code		10	og. Citizen of What Co	untry?
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23s or 28s-f show empty injury or other traumatic event, the Medical Examinal ruled its indiffied at ONCs.	by Funeral	30 Locust Street 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		21157 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No		Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within 72 hou iene. 'than "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired omemaker	furina most of wo	rking	Own Home	
nd 2	should be filed wand Mental Hygies marked other tiumatic event, the	Be	17. Father's Name (First, Middle, Last) Mordecai M. Jacob	9				me (First, Middle, M	faiden Sumame)	
aryla	should and Mer marke umatic	ဥ	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a			City or Town, State, 2	Tip Code)
	1 and 2 Health a em 27 le		Barbara E. Weitze		. Place of Dispo	sition (Name of		Maryland 2	21811 20c. Location - City or	Town, State
Baltimore,	Pages nent of t ant: If its ary or o		1 ☐ Burial 2 ② Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	lto/Was		ory 1-1	8-2004 L	aurel, Mar	y1and
Balt	permit. Departr Importe eny inju		21. Signature of Funeral Service License	1	16	30 Edmond	son Aver	nue Catons	onsville, i	Inc. 21228
	Physician		23a. Pan1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition		ath. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death Moin TVI J
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
	pe pisi	Examiner	Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury	Due to (or se a cone	equanes of):					
8760,	icate be executed physicien and s the buriat-transit	Icai		Due to (or as a consi	equence of):					
P.O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the t	inderlying cause give	en in Part I.		eaccoluse contribute to	
Division of Vital Records,	S 50	Completed	Diabetes 1	Mellitus				24a. Was ar autops perform 1 Yes 2	y / prior to d	topsy findings available completion of cause of 2 No
Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	or /	ath <i>(Check only one</i> Home 5 ☐ Reside	e) Ince 6 □Other (Spec	cify)
on of	Attending Phy ir death. ector: After thi by the funeral of		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injun Wor	/ at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Divisi	of or Attendiate of a ster death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (Str. City or Town	reet and Number or Ru , State)	iral Route Number,
	To the Hospitel or Attending Physicien: The twithin 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	edicai C		sician: To the best of my k ner: On the basis of exam- and manner stated.						
	To the within To the complete	Me	29b. Signature and title of perifier	MINO)	29c, Licens			od. Date signed (Monti	
	5	ata.	30. Name and address of pers 1 who could be a second of the second of th	1/ 0	Aver	Print)	saltin	iore N	lary (and	15, 2004 ed 21227
	Regist	ate rar	JAN 2 0 2004	See St	Apres	w				

		•	For State Registrar	Sta	ate of M	arylan	nd / Depa			ealth a		ental Hy	giene Reg. No	-211	14	0 1	57
*	Physici		Decedent's Name (First, Middle, THELMA	Last)		WINST	'ON					2. Date of De Month JANUAR	Day		ear 4	3. Time of Dea	th M
Ì	/Medic Examin		4a. Facility Name (If not institution,		and number,		ON			Location of	of Death	<u></u>		County of E	Death	IMORE	
	Funeral Director			5. Sex 1 ☐ M 2	7. A	ge (<i>In yr</i> s. 75	last birthday) Yrs.		1 Year Days	If Under Hours	24 Hrs.	8. Date of Bi	rth 179 ⁷ 28 ⁰	9.	Birthpla Country	ce (State or For VA	'eign
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD BALTIM	ORE	_		ty, Town or Lo		ON						100	d. Inside City Lir	
	3a or 28a-	Funeral Director	10e. Street and Number 731 N. AVONDALE				,	10f. Zij	Code	1222			10g. Cit	izen of Wha	t Country	y?	
036	d within 72 hours after death with the Maryland jiene. r than "natural", or fleme 23a or 28a-f ehow the Medical Evanti or must be motified at	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 [as Decedent med Forces Yes 2 Yes, Give ear or Dates:	? •No	1	Was Dece If Yes, spe 1 Yes		ispanic Ori n, Mexican Specify:	gin? (Spec n, Puerto F	cify Yes or Ne Rican, etc.)	D-	14. Race - / Black, V Specify:	Americar White, et BLA	c.	
21215-0036	within ene. than "	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12) 12	grade com		5+)	life.	dent's Usu kind of we DO NOT L	ork done d se retired	during mosi)	t of workin	g	16b. K	ind of Busin		stry	
Maryland 2	be filed stal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, L				1					(First, Middle		Sumame)			
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationsh JOSEPH R. WINST 20a. Method of Disposition			20b. F		OAK	STRE		ALTI	Houte Numb	MD 2				
Baltimore,	permit. Peges Depertment of himportant: If ite any injury or of one		1 Disposition 1 Disp	ecify)	al from State	, (OWNSVI	matory or a LLE C 2. Name a	ether place EMET and Addres	ERY !	1-23 y JAM	0.1	ROWI MORT	NSVILL ON &	E N	4D	INC
STATES .	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	ns that cause use on each Due to (or as	u me	trial	ter the mo	-	g, such as		respiratory a	rrest,		11	Approximate interval Between Onset and Death	
8760,	ate be executed thysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as									7.7.			
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	yes, outcom □Live birth □Pregnant a □Unknown	2 Feta	al death 3	⊒Ectopic p ⊒ Other (s			7.0-			23d. Date of Month		/ Pay Year	
	ires that signed d be de	þ	Part II. Dther significant conditio	s contribut	ing to death	but not res	sulting in the u	inderlying	cause give	en in Part I.			tobacco u Yes 2			cause of death	
Vital Records,		Completed										24a. Was auto perfe 1 🗆 Yes	psy ormed?	prior	to comp	sy findings availabletion of cause	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospit	al·				Oth	25		(Check only					
of		tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28	a. Date of Inj (Month, D		28b. Time of Injury		28c. Injun Worl	/ at	2	ne 5 Res 8d. Describe			Specify)		
Division	el or Attending s after death. il Director: After d in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be	e. Place of Ir building, e	njury - At h atc. <i>(Speci</i>	ome, larm, st	reet, factor	y, office		2	8f. Location (City or To			or Rural f	Route Number,	
<	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical (29a. Certifier 1 Certifyin (Check only one)	xaminer: (: To the bes on the basis and manner s	of examina	owledge, deat ation and/or in	h occurred	at the tim	ne, date an pinion, dea	id place, a ith occurre	nd due to the d at the time,	cause(s)	and manne I place, and	r as stat	ted. he cause(s)	
	To the To the comp	W	29b. Signature and title of certifier		~			29		number 1491	1			te signed (M			
2	10		30. Name and address of person of Michael E. N	C/11/13	im N	1.D.	m 23a) (Type,	Print) Fra	nKI:	n So	jvar	e Dr.			•	1.	
	Sta Regist		31. Date liled (Month, Day, Year)	2 0 20	32. Regis	trads Signa	ature #	Son	st.								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** JOANN WALDECKER JANUARY 18 2004 14:27 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BERLIN WORCESTER CO. ATLANTIC GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 18 19 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 66 212-32-9502 Yrs Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or items 23a or 28e-f show marked other than "natural", or items 23s or 28e-f shov matic event, the Maxical Examinar roust by notified at Sussex Co. 1 ☐ Yes 2 No Del.. Dagsboro Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19939 U.S.A. Rt. 1 Box 46 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H permit. Pages 1 and 2 should b Department of Heath and Menit Important: If item 27 is marked any injury or other traumatic et once. Delbert Shafer Laura Beares ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick A. Waldecker (Husband) Rt. 1 Box 46, Dagsboro, Del. 19939 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 01/22/04 Elkridge, Md. 21. Signature of Funera Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home p.A. 3204 Mountain Road, Pasadena, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final disease or condition resulting in death) neumoni Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 month Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 25. Was case referred to redical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25/No 1 Inpatient Medical Certification; To 1 Tes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thway or Berlin MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1/18/2004

Waldecker,

2004 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2004 Jan. Lee Mace Willey, Jr. 5:20 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Nursing & Rehabilitation Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1⊠M 2□ F 214-30-6422 70 Director Sept. 8, Maryland Usual Residence of Decedent filed within 72 hours efter death with the Maryland Hygiene.
The ture! or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23a or 28a-f show the Medical Exprimer must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Granite 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10825 Summit Ave. 21163 Funeral United States 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?

1⊠ Yes 2□ No 1953·
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2XI Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced 1956 Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 end 2 should be filed w Depertment of Health end Mental Hygien Important: If Item 27 is marked other the any Injury or other treasures. 12th Electrician Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Mace Willey, Sr. Vida Marcella Mettee ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Huckle Drive Hampstead, MD 21074 Michael Willey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 No Cremation 3 ☐ Removal from State Carroll Cremation Inc. 2004 Hampstead, MD Jan. 21 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Pandato Come Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificete be executed effor death. attending physiclan and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown ð 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has page 1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours effer To the Funerel Dires completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ddleten 0688 Pook Read, Westminsten MD 21157 John State Registrar

	Í	1 - For State Registrar	State of Marylan		nt of Health and te of Death		giene Reg. No. 200	4 0116
Physici	ian	1. Decedent's Name (First, Middle, Las.				2. Date of Dea Month	Day H Year	3. Time of Death
/Medi Examir	cal	EDYTHE JOY 4a. Fecility Name (If not institution, give 5. Social Security Number 6. Se	Ith-Bel Ai	r Be	r, Town, or Location of Deat	8. Date of Birth	4c. County of Dea	oth State or Foreign
Funeral Director		478-14-9842	□ M 2(\$\forall F \) 86	Yrs. Months	Days Hours Min.	(Month, Day Apr. 25		Towa
h the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Har	ford	y, Town or Location Bel Ai	r			10d. Inside City Limit. 12∑ Yes 2 ☐ N
ith the	Director	10e. Street and Number		10f. Z	ip Code		10g. Citizen of What C	ountry?
s 23a	ral	532 East Broadw	ay 12. Was Decedent Ever in U.	S 13 Was Dag	21014	Specify Ves or No	US.	
Ind 21215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. d other than "natural", or Items 23a or 28s-f show event, the Medical Examinar count be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		edent of Hispanic Origin? (S ecrify Cuban, Mexican, Puer 212 No Specify:	to Rican, etc.)	Black, Wh	
Maryland 21215-0036 d 2 should be filed within 72 hours alt th and Mental Hygiene. 77 Is marked other than "natural", or treumatic event, the Medical Exam.	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ual Occupation work done during most of wo use retired)	irking	16b. Kind of Busines	s/Industry
212 212 3d with giene gritha	Som	Elementary/Secondary (0-12)	2	Cosmot	cologist		Cosmetic/	Beauty
and The file of oth	Be	17. Father's Name (First, Middle, Last) Chester Arth		wrth	18. Mother's Na Sula	me <i>(First, Middl</i> e. E lizab	Maiden Sumame) eth Ha	in
re, Maryland 21215 s 1 and 2 should be filed within 7 Health and Mental Hygiene, item 27 is marked other than "n other traumatic event, the Mad	To	19a. Informant's Name/Relationship (7		19b. Mailing Addres	ss (Street and Number or R	ural Route Numbe	er, City or Town, State,	
and and and and and and and and and and		Michael Waller -		532 East	Broadway, Be	l Air, M	aryland 2 20c. Location - City of	1014
Baltimore, Mispermit. Peges 1 and 2 Department of Health is Important: If tiem 27 is any injury or other tra once.		20a. Method of Disposition 1226Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crematory or	r other place)			
Itin nit. Pe artmer artmort injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral/Service Licen		ntain Chri	LSTIAN $\frac{1}{1}$ I $\frac{1}{1}$	6/04	Joppa, M	
Depa Depa Impo		> Challel	my		st Broadway,			21014
) Physician		23a. Part1. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line.		ode of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq					
uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				
8760, rate be executed only sicien and the burial-transit	cal	resulting in death) Last	Due to (or as a conseq	uence of):				
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnative birth 2 Feta 4 Pregnant at time of c	il death 3 □Ectopic			23d. Date of d Month	elivery Day Year
cords, P. vequires that been signed by	d by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did to		to the cause of death? Probably 4 Dunknow
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f Vital Reysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?				eath (Check only o	one)	
- × v	၉	1 Yes 2 No 27. Magner of Death		ER/Outpatient 3 1	DOA Other: Nursing		dence 6 Other (Sp	ecify)
ding h. After	ation	1 Natural 5 ☐ Pending investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No			
in the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, lact fy)	ory, office	28l. Location (: City or Tox	Street and Number or I wn, State)	Rural Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical (nysician: To the best of my knowning: On the basis of examination and manner stated.					
To the within 2 To the complet	Me	29b. Signature and title of certifier	3		29c. License number		29d. Date signed (Mo.	nth, Day, Year)
0		> DR M	D		D34652		Junuary	14, 2004
90		30. Name and address of person who	11 2 North	M 23a) (Type, Print) AVCAVC	0 1 1.	Mary In.	nd 210	14
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature &	ford			

		ı	1 - For Stote Registrar Amend Item #17	State of Ma						and Me		giene Reg. No.	7111] 4	01161
			Decedent's Name (First, Middle, Last								2. Date of Dea			ear	3. Time of Death
	Physici /Medio		N	like Walte	r Wal	.ega					1	16	20	04	6:20 PM
	Examin		4a. Fecility Name (If not institution, give	street and number)	,	T 1	4b. City, T	own, or	Location o	of Death		4c.	County of	T	
			5. Social Security Number (6. Se	4 RE HOS	in yrs. la	A (st birthday)	If Under 1		If Under		8. Date of Birt	th	DA/9	. Birthpia	10 RE ace (State or Foreign
9	Funeral Director			X M 2□ F	88	Yrs.	Months	Days	Hours	Min.	Oct. 9	y. Year)	1.5	Mary	y) /land
	pg .		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	ocation							10	d. Inside City Limits
	Aaryla f eho	ō	Maryland Baltim	ore		altimo									1 ☐ Yes 2 🎇 No
	r 28a-	Director	10e. Street and Number				10f. Zip (10g. Citi	izen of Wha	at Count	ry?
	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f ehow official Examination publish at		5694 Arnhem Roa	d 					206				U.S.		
	tema tema	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decede If Yes, speci	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Black,	America White, e	
36	irs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 N If Yes, Give Year or Dates:	0		1 ☐ Yes 2	No No	Specify:				Specify:	Whi	te
5-0036	2 hou	ted	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Usual	Occupa	ition	t of workin	ıa .	16b. K	ind of Busin	ness/Indi	ustry
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use	e retired,)	o workin	'y		C 1'	_	
121	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)			Jet	Mecha unk	ante		r's Name	(First, Middle,		S. Ai	r FC	orce unk
and	Mental Parked of	To Be	7. 1 4. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10								(not as			_	
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	12 mg		Mike Walega Jr.	/ son	T		Foxg1		Lane		ltimor				
ore	Pages 1 all nent of Hea int: If Itam iny or otha		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	Ce	metery, cre	osition (Nam matory or oti	her plac			ate		cation - Cit		
Baltimore			4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Hol		SS Cen			1/20/					Maryland
Ba	permit. Departr Importa eny inje) Jecone zn	amucu	Men	4	1001 R	itch	ie Hi	se org Lghwa	y Bal	timo	re, M	raı aryl	Home, P.A. and 21225
*	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lin	the death. e.	. Do not en	ter the mode	of dying	g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
10%	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. Cere Due to (or as a		ence of):	scul	AR	Ŧĸ	1 FAI	ec/				
8760,	certificate be executed utility by sician and use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):									
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	quires that in signed t uid be det	ed by P	Part II. Other significant conditions co	entributing to death bu	it not resul	lting in the u	underlying ca	use give	en in Part I.		23e. Did t				cause of death?
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/ita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	777						of Death	(Check only o	one)			
of Vital	this al di	To.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatie		A Othe	4 🗆 140		ne 5 Resident			(Specify)	
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		iry - At hor c. (Specify)	me, farm, st	reet, factory,	, office		2	8f. Location (City or Tox			or Rural	Route Number,
7	ne Hospita 124 hours ne Funera letely fille	Medical C		ysician: To the best of iner: On the basis of and manner sta	examinati										
	To th withir To th comp	Me	29b. Signature and title of certifier						number			29d. Da	te signed (/	Month, E	ay, Year)
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4	Sta Regist		30. Name and address of person who of DR, TeFF eRV S 31. Date filed (Month, Day, Year)	WETT 90	00 F	RANI	Print)	5,9	HAR	EL	P. B.	4/Ti	more	= 1	11 21237

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			Registrar 1. Decedent's Name (First, I	Aiddle Las	*1		Ce	rtificate	of Dea	th	a Data of D	Reg. No	<u>.</u> 4UI	JH	U	06
	Physic		Danny	A .	9	Wea	aver				2. Date of De Month	Da		ear	3. Time of Dea	th M
1	/Medi Exami		4a. Facility Name (If not insti	tution, give	street and number)			4b. City, To	wn, or Local	ion of Death	JANUAR'	-	2004 :. County of I	Death	10:20A.	
			7 EAST WASHIN					HAGERS				W	ASHINO			
i di	Funeral Director		5. Social Security Number 458-78-58	6. Se	X ZM 2□F 7. Ag	e (In yrs. las 55	s <i>t bir</i> thday) 5 Yrs.	Months [nder 24 Hrs. Irs Min.	8. Date of Bir (Month, Da		TAT-	Birthplac Country	ce (State or For) Falls,	reign
(4)	pur *		Usual Residence of Deceder	nt		10- 0::		1			October	8, 1	948 '''	Texa	es	
	the Maryland r 28a-f show	to		ashin	gton		Town or Lo Hager							10d	I. Inside City Lir 1 XYes 2 □	
	th with the 23a or 28a ast be noti	al Director	10e. Street and Number 9 E. Wash	.ngtc	n Stree	t		10f. Zip Co 217					izen of Wha	t Country	/?	
920	hours after death with the Maryland tural', or items 23a or 28a-f show at Exartater must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 2 Divo		12. Was Decedent Armed Forces? 1X Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Was Decedent f Yes, specify			ecify Yes or No Rican, etc.))	14. Race - A Black, V Specify: W	Vhite, etc	2.	
21215-0036	n 72	Completed	(Specify only h		cation e completed)		16a. Dece (Give	ient's Usual C kind of work of DO NOT use	ccupation	most of worki	ng	16b. K	ind of Busin			
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nd	be filed tal Hygi d other	Be	17. Father's Name (First, Mic	dle, Last)				<u> </u>			(First, Middle,			1105		
Maryland	2 should be and Mental is marked a	P		Weav						Oxema			nknow			
	5 # Z # E		19a. Informant's Name/Rela Jaye LaMor				196. Mailir	g Address (S Monte	treet and Nu rey La	mber or Rura ane, B	Route Number	er, City o ge S	or Town, Stat Summit	te, Zip Co • PA	17214	,
Baltimore,	m O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Other	ion 3 □F	Removal from State	1		sition (Name natory or othe wn Crei		1	2004		ocation - City			
Balti	permit. Page Department Important: If any injury of once.		21. Signature of Funeral Sec				22	. Name and A	ddress of Fa	cility	neral	_	erstow e. Ir		Ш	
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<u>.</u>	uires that the de signed by the d be detached		Part II. Other significant con	ditions cor	tributing to death bu	t not resultin	ng in the un	derlying caus	given in Pa	rt I.	23e. Did to	bacco u	se contribute	to the c	ause of death?	
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Il Records,		Completed									24a. Was a autop perfor 1 X Yes	sy	24b. Were prior to death	to comple	findings availab etion of cause o	ble of
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	ding After fune	tion: To	1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pe		1 Inpatier 28a. Date of Injury (Month, Day)		Outpatient b. Time of Injury	128c.	Injury at Work?	2	e 5 Resid	ence o ow injury	Other (S)	pecify) 5	CENE	-
Division	N or Attending after death. Director: After I in by the funer	Certification;	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of Injurbuilding, etc.	y - At home (Specify)	, farm, stre			-	Bf. Location (S City or Tow	treet and n, State)	Number or	Rural Ro	ute Number,	_
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	6		> hay h		mis			0.	C.M.E	•	J <i>Z</i>	MUAT	RY 7,2	.004		
	/		30. Name and address of pers		-	ath (Item 23		rint)					•		1201	
A.	Sta	·C	31. Date filed (Month, Day, Ye	ar)	32. Registrar	's Signature		lili Per	ni Str	eet, B	altimoi	e, I	mary1.a	ina 2	:1201	
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			For State Registrar	State of Ma	•	epaπme <i>Certifica</i>			_	gien Reg. Ne	-200	04	01163
	Physicia	an	Decedent's Name (First, Middle, Las	")					2. Date of De Month	ath Da	ay	Yeer	3. Time of Death
	/Medic	al	SYLVIA ANI 4a. Fecility Name (If not institution, give			4h Ci	ty Town or	Location of Death	Vanua	· * ·	5,72 c. County of	Death	1:15 am
	Examin				Cente			dale			_ ′		оге
	Funeral		Franklin Square 5. Social Security Number 6. Se	7. Age	(In yrs. last bin	thday) If Und	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		9. Birthpla	ace (State or Foreign
	Director		217-50-5977	□M 2 X 0F	62	Yrs.			Jan 30				RYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location						10	d. Inside City Limits
	Mary 9-f sh	tor	MARYLAND BALTIM	IORE	В	ALTIMOF	RE						1 ☐ Yes 2 📉 No
	death with the Maryland ms 23e or 28e-f show rmast be rediffed at	Director	10e. Street and Number			10f.	Zip Code			10g. C	itizen of W	hat Count	ry?
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	ter de Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2XXX	o verin u.s.			spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)			, White, e	
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an _ C	ould be t Mental l arked o	To Be	LOUIS MILTON GRID	NAGE				ANNA M	WRIGHT	ı			
<u>O</u> €	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Man		19a. informant's Name/Relationship (7	ype, Print)	19b	. Mailing Addre	ess (Street a	and Number or Ru	ral Route Numb	er, City	or Town, S	State, Zip	Code)
C Z	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "naturel; or Items 23e or 28e-f show or other treumatic event, the Medical Examinating man be rediffed at		Nellie E. Grinage	e/Niece		655 HO		Ave., B	altimor Date		Maryl Location - 0		
2 5	ages 1 nt of H : If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐		cemeter	y, crematory o	r other plac					•	
✓ OU altimore	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		*4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		DULA		and Addres	ss of Facility					ARYLAND
_ B	Dep Imp any		Charles 1	4. Jou	rell	WILLIZ 321 S	AM C E S PHII	BROWN COM LADELPHIA	M FUNER BLVD,	AL I ABEI	HOME- RDEEN	HARFO MD 2	ORD, P.A. 21001
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do r	not enter the m	ode of dying	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Metas	tasis		an	Canc	er			>	Imonth
	/Medical Examiner		resulting in dealiny	Due to (or as a	consequence	of):							
		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence	of):							
	executed in and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
90,	oe exe cian al ourial-l		resulting in death) Last	Due to (or as a	a consequence	of):							
68760,	tificate be executed ig physician and as the burial-transit	edical		d									
Box 6	Attending Physicien: The law requires that the death certificate be rideath. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		المالة المالة					23d. Date	of deliver	у
ă.	death	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		5 Other	pregnancy (specify)				Mon	th (Day Year
O. O.	at the	Phys	9 Unknown					an in Dard I	220 Did 1	obacco	uso contri	buta to the	e cause of death?
s,	ires the signer signer d'be d	l by	Part II. Other significent conditions of	ontributing to death bu	it not resulting if	i the underlyin	y cause give	en in Fatti.	1 🗆				ibly 4 DUnknown
Sorce	v requ	Completed							24a. Was	an	24b. W	ere autop	sy findings available
Re	he lav e has age 2	dwo							auto perfo	psy ormed? 2	pr de	ior to com eath? ⊒ Yes 2	pletion of cause of
ital	ien: Trifical	Be C	25. Was case referred to medical examiner?					26. Place of Dea					
5	hysic his ce il direc	To	1 ☐ Yes 2 XNo	Hospital: 1 Inpatie		-		4 Nursing H	ome 5 ☐ Resi)
Division of Vital Records, P.O.	ing P. After t funera	ion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. 1	Fime of njury M	28c. Injury Work	/at <br Yes 2 □ No	28d. Describe	now inju	ury occurre	a	
risic	Attency death ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, fa							r or Rural	Route Number,
ρi	s after s after al Dire	Certification:	4 Homicide determined	building, etc	:. (Specity)				City or To	wn, stat	Θ)		
1	To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death. To the Funerel Director: Atter this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical (29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best of niner: On the basis of and manner sta	examination an	dor investigat	ed at the timion, in my or	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s	s) and man	ner as sta nd due to	ited. the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	Λ	01	:	29c. License			29d. Da	ate signed	(Month, D	Day, Year)
	/		25 Eldas	alro	- ruys.	cian	P00	5430	3	Ja	nua	M	15, 2004
1			30. Name and address of person who	completed cause of de		(Type, Print)	Ш		2 11	,		1	
_	<u></u>		Dr. Tyad Eldadal 31. Date illed (Molin Ray, Yell) 20	9000 0.4 32 Registra	Frank r's Signature	Alin 5	guar	e Drive	2 Koalti	α	ore	MD.	21237
	Sta Registr		JAN W ZU	U4 170	1 St.	Grant.	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #5 PER FH G827 1/29/04 Rertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 January 5:30 PMM Edwin Eugene Zimmerman, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Braddock Heights Vindobona Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Sacurity/Number 214-36-055-7 7. Age (In yrs. last birthday) 8. Date of Birth Mar 126, Year 32 9. Birthplace (State or Foreign Mary Land 6 Sax **Funeral** 1 € M 2 □ F 71 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 No New Market **Funeral Director** Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21774 6540 New London Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23s any injury or other traumatic event, Ita Middeal Examiner must anne. 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes XX No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School System Maintenance Mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna A. Waltz Ray H. Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6540 New London Road, New Market, MD 21774 Mrs. Barbara A. Zimmerman, wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 14 Bunal 2 ☐ Cremation 3 ☐ Removal from State Methodist Church Cametery Jan. 15, 2004 New Market, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Keeney and Basford PA_Funeral_Home 21. Signature of Euneral Service Licensee MO0255 106 East Church St., Frederick, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mellonan pa /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 autopsy performed? 1 Yes 20 No 2 X No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaufmann,

Robert L.

31. Date filed (Month, Day, Year)

M.D.,

32. Registrar's Signature

139

300 West Ninth Street, Frederick, MD 21701

January 12, 2004

			1 - For State Registrar	State of Marylan	d / Depa				
***	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last IRENE CALL ADD) 4a. Facility Name (If not institution, give DOCTOR S COMMUNITY)	ICKS e street and number)		4b. City, Town, or Loca	2. Date of i Month William ation of Death	4c. County of De	1 31/5PM
	Funeral Director		5. Social Security Number 6. S		last birthday) Yrs.	If Under 1 Year If U	Juder 24 Hrs. 8. Date of Month, AUGUST	Day, Year) (irthplace (State or Foreign Country) NX, NEW YORK
	ath with the Maryland 23s or 28s-f ehow	ector	MD 10b. County PRINCE G		y, Town or Lo	LVILLE			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
36	within 72 hours after death with the Maryland ene. than "natural", or lterns 23e or 28e-f ehow he Madical Exama not into tradified at	by Funeral Director	10450 LOTTSFORD 11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	RD. 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		10f. Zip Code 20721 Was Decedent of Hispan If Yes, specify Cuban, Me	ilc Origin? (Specify Yes or exican, Puerto Rican, etc.) ecify:	10g. Citizen of What C U.S.A. No- 14. Race - Arr Black, Wh Specify:	nencan Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Items any injury or other traumatic event, the Medical Exura in 10008.	Completed t	15. Decedent's Et (Specify only highest gra	ducation de completed) College (1-4or 5+) 5+	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) PTROLLER		16b. Kind of Busines	ŕ
aryland	2 should be fill and Mental H is markad oth sumatic even	To Be	17. Father's Name (First, Middle, Last) GEORGE H. ADDICK 19a. Informant's Name/Relationship (S Type, Print)	19b. Maili		Mother's Name (First, Midd EUGENIA B. C. Jumber or Rural Route Nun	ALL	Zip Code)
	ages 1 and 2 int of Health a t: If item 27 i y or other tra		GEORGE A.ADDICKS/I	Removal from State		osition (Name of matory or other place)	COPIAGUE, N	20c. Location - City o	r Town, State
Baltimore,	permit. Pages Department of t Important: If ite any injury or of		1000	wart Mo133	8 76	2. Name and Address of Ol SANDY SP.	Facility FLECK FU	REL, MD 2070	INC.
760,	Physician /Medical Examiner is parial-transit	cal Examiner	23a. Part1. Enter the disease, or com shock, or heart failede. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0	uence of):				Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
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ital Rec	2 2	Be Comple	25. Was case referred to medical	1.		26.	ре	topsy prior to death? 2 No 1 Ye	utopsy findings available completion of cause of s 2 \(\text{No} \)
Division of Vital Records,	Phy this	ရ	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	nt 3□ DOA Other: 4	□ Nursing Home 5 □ Re 28d. Describ		ecify)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify	y) 		City or 1	(Street and Number or Fown, State)	
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam 29b. Signature and title of certifief	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the time, da vestigation, in my opinion 29c. License num	i, death occurred at the time	e, date and place, and du	e to the cause(s)
,	m = 3 = 8		30. Name and address of person who	completed carse of death (Item	1 23a) (Type,	920T	979	29d. Date signed (Mon	20706
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrate Signa	-	Souls .	fice, Lon		

	1	For State Registrar			d / Department of h Certificate of	lealth and	Mental Hy			01166
		1. Decedent's Name (First, Middle, La	ast)		A = A + A C		2. Date of De Month	Day	Year	3. Time of Death
Physicia /Medic	al -	JANE			ADAMS		JANUAR	34	2004 County of Death	
Examin	er :	4a. Facility Name (If not institution, gir	ve street and number)	an:	Ab. City, Town, o	r Location of Dea	ith Z	4C. C	ounty of Death	
Funeral Director			Sex 7. Ag	e (in yks. i 58	last birthday) If Under 1 Year Months Days	If Under 24 Hr. Hours Min		y, Year)	Cou	place (State or Foreign ntry) hington, DC
ס		Usual Residence of Decedent		40- 01-						10d. Inside City Limits
death with the Maryland me 23a or 28a-f ehow rust be notified at	5	10a. State 10b. County			y, Town or Location					1 ☐ Yes 2 ☑ No
28a-f	Funeral Director	MD Talbot 10e. Street and Number		T:	rappe 10f. Zip Code			10g. Citiz	en of What Cou	intry?
Sa or	흐	29290 Maple Aver	1116			673		US	Α	
Me 2	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.			Specify Yes or No		4. Race - Ameri Black, White	
jiene. r then "naturel", or lieme 23a or 28a-f ehow the Medical Examinut must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XX If Yes, Give Year or Dates:		1 □ Yes XXNo					Thite
natur	Completed	15. Decedent's 8 (Specify only highest g.	ducation rade completed)		16a. Decedent's Usual Occu (Give kind of work done	during most of w	orking	16b. Kin	d of Business/Ir	ndustry
ene. then "natural", or its ne Wedical Examin	ldm	Elementary/Secondary (0-12)	College (1-4or	5+)	'life. DO NOT use retire Homemaker	10)			wn Home	
Hygie other t	ပ္ပိ	17. Father's Name (First, Middle, Las	it) 4		Homemaker	18. Mother's Na	ame (First, Middle			
fental rked o tic eve	To Be	Clarence Harlowe				Margue	rite Orr			
i Health and Mental Hyg Item 27 Ie merked othe other traumetic event,	-	19a. Informant's Name/Relationship			19b. Mailing Address (Street			er, City or	Town, State, Zi	ip Code)
ealth a n 27 le ner trai		M. Gerald Adams	(Husband)		29290 Maple A					
of Her Item		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	□Romoval from State	20b. P	Place of Disposition (Name of cometery, crematory or other place	асе)	Date	20c. Loc	ation - City or T	own, State
ant: I		'4 □Donation 5 □ Other (Spec		Me	tro Crematory		9/2004		imore,	MD
Important: If Its eny injury or of once.		21. Signature of Funeral Service Do	ensee		22. Name and Addr Hardest					. 200
7 E 9 Q		J. J.	- liesting that sauge	d the deat			ue, Annaj ac or respiratory a		, MD 21	Approximate
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Medical aminer		resulting in death)	Due to (or as	9900000		DISEX	105			5 YEARS
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ysician and e burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as	a consec	uence of):					
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attending phys for use as the	Physician/Media	IF FEMALE:								
ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Il death 3 Ectopic pregnand	су		2	3d. Date of deli- Month	very Day Year
the a	/slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of c	death 5 🗌 Other (specify)					
signed by the signed be detached	Ph.	Part II. Other significant conditions	contributing to death I	but not res	sulting in the underlying cause g	iven in Part I.	23e. Did	obacco us	se contribute to	the cause of death?
og p	d by	DIABETES, HYPE	RTENSION	1,	STATUS POST		10	Yes 2 [°] ∑	¶No 3□Pro	obably 4 Unknown
should b	Completed	VENTRICULAR REST	TORATION AN	D M	MRAL VALVE RE	PAR.	24a. Was		24b. Were au	topsy findings available
e has	omp		T VENTRICE				auto perf	psy ormed?	death?	ompletion of cause of
is certificate h director, page	a	25. Was case referred to medical			7(23.3		eath Check on			
direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2	ER/Outpatient 3 DOA O	ther: 4 🗆 Nursing	Home 5 ☐ Res	idence 6	□Other (Spec	ofy)
After this tuneral di	Ju: T	27. Manner of Death 1. Matural 5 ☐ Pending	28a. Date of Inj (Month, D.	ury ay Year)		ork?	28d. Describe	how injury	occurred	
or: A	catle	2 Accident investigat	h-			Yes 2 No	004 1	(0)	111	and Courts Alicentes
Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Ir building, e	njury - At h atc. <i>(Speci</i>	nome, farm, street, factory, office fy)	•	City or To	wn, State)	r Number or Hu	ral Route Number,
within 24 hours after deal To the Funeral Director: completely filled in by the	Medical C			of examin	owledge, death occurred at the ation and/or investigation, in my					
ormple	Me	29b. Signature and title of certifier	0		29c. Licer	nse number		29d. Date	signed (Month	n, Day, Year)
Ρō		> Solus k	& , MD		(23-000		JANL	Acy 1-	7,2004
10		30. Name and address of person wh	- completed source of	death (Ite						
St	ate	31. Date filed (Month, Day, Year)		trar's Sign	ature &					
Regist		JAN 2 1 2	004	مهدي مستار إندي	As Some	31				

hin 24 hours after deatl the Funaral Director: To the Hospital filled within 0

29a. Certifier 29b. Signature and title of certif

January 17, 2004

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

State Registrar

DHMH 17 Rev 1/2001

Medical

MAMARITO
31. Date filed (Month, Day, Year) JAN 2 1

32. Registrar's Signature

BEU

	1 - State Registrar	State of Maryland / D	Certificate of Death	niviental Hygiene Reg. No. 2	004 01168
	Decedent's Name (First, Middle, Last,			2. Date of Death	3. Time of Death
Physician	Matsuko Adam	ıq		JANUARY 09	2004 6:42 PM
/Medical Examiner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of De		nty of Death
	SAINT AGNES +	tealthcare	BALTIMORE	Not	Applicable
Funeral Director	5. Social Security Number 6. Security Number 6. Security Number 10.	THE OFFICE	hday) If Under 1 Year If Under 24 H Months Days Hours M		9 Birthplace (State or Foreign
	Usual Residence of Decedent				
Department of Health and Mental Hygiene "natural", or Items 23a or 28e-f show Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Model Examination instituted at once. To Be Completed by Funeral Director	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
be notified be notified Director	Maryland Baltimore	Baltim			
Dir	10e. Street and Number		10f. Zip Code	10g. Citizen	of What Country?
diner must	3317 Washington Bo	oulevard 12. Was Decedent Ever in U.S.	21227	Japan	Rece - American Indian,
E E	1 Never Married 2 Married	Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Spe	^{city:} Asian
t, the Madeal F Completed	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupation	16b. Kind of	Business/Industry
M d	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of v life. DO NOT use retired)	vorking	
3 6	12		Hotel Maid	Hotel	
event Be (17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Maiden Sum	ame)
To	Jisaburo Hikida		Asae Ku	ıbota	
E C	19a. Informant's Name/Relationship (Ty	pe, Print) 19b.	Mailing Address (Street and Number or	Rural Route Number, City or Tow	vn, State, Zip Code)
er tr	Jeannette Collin		05 Main Creek Driv	e, Pasadena, Ma	ryland 21122
r oth	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	comoton	Disposition (Name of r, crematory or other place)	Date 20c. Locatio	n - City or Town, Stete
n d	'4 □ Donation 5 □ Other (Specify)		Park Cemetery Jan	uary 15,04 Balt	imore, Maryland
eny in	21. Signatur > Funeral Service Licens	· // / / / / / / / / / / / / / / / / /	22. Name and Address of Facility Loudon Park Funer.	al Home	
* a	Ma D. Jy	Jacob Collin	3620 Wilkens Aven	ue, Baltimore,	Maryland 21229
	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	darions that caused the death. Do not cause on each line.	ot enter the mode of dying, such as card	ac or respiratory arrest,	Approximate Interval Between
cian	Immediate Cause (Final disease or condition	A A A	1BARACHNOTD H		Onset and Death
ícal iner	resulting in death)	Due to (or as a consequence o			
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Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	f):		
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etached for use as the bu	IF FEMALE:	20 If you system of process		70-	T.
of for use as the b	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy NA	23d. E	Date of delivery Month Day Year
y Physic	1 ☐ Yes 2 XNo 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		NIA.
Ph	Part II. Other significant conditions cor	tributing to death but not regulting in	the underlying equip given in Bort I	230. Did tahanan una an	ontribute to the cause of death?
ه ۾	Tak ii. Olio olgiiiloan ooranoo	and the second of the second o	the underlying cause given in Fatti.	1 ☐ Yes 2 ☐ No	
etec				10 165 20 100	3 Trobably 4 Olikilowii
Page 2 should t				autopsy	Were autopsy findings available prior to completion of cause of
Cor				performed? 1 ☐ Yes 2 🖔 No	death? 1 ☐ Yes 2 No
director, page 2 s	25. Was case referred to medical examiner?			eath Check onl one	
0	10163 22110	ospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 Residence 6 □0	Other (Specify)
tuneral tlon; T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury at work?	28d. Describe how injury occi	
the fu	2 Accident investigation		A M 1 □ Yes 2 □ No	NIA	
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Num City or Town, State)	
rti p			NA		NIA
lled in by the funera Certification;	- C	ician: To the best of my knowledge.	death occurred at the time, date and pla	ce, and due to the cause(s) and recurred at the time, date and place	
eletely filled in by the	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Examination	ner: On the basis of examination and and manner stated.	or investigation, in my opinion, death oc		manner as stated. e, and due to the cause(s)
Medical Certif	(Check only 2 Medical Examil	ier: On the basis of examination and	or investigation, in my opinion, death oc 29c. License number		manner as stated. e, and due to the cause(s) med (Month, Day, Year)
Medical Certifi	one)	er: On the basis of examination and and manner stated.		29d. Date sign	e, and due to the cause(s) ned (Month, Day, Year)
completely filled in by Medical Certiff	29b. Signature and title of certifier	er: On the basis of examination and and manner stated.	29c. License number P (6702	29d. Date sign	ned (Month, Day, Year)
pletely fill edical	29b. Signature and title of certifier	and manner stated. Impleted cause of death (Item 23a) (1	29c. License number P (6702	29d. Date sign	ned (Month, Day, Year)

		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of	Death	2. Date of Dea	Reg. No.	2004	3. Time of Death
Physici /Medi		Bonita Suver Ada	ns				January		200 ^{Year}	5:38 р м
Examir	ner	4a. Facility Name (If not institution, give Gilchrist Hospice			4b. City, Town, Towso:	or Location of Death		4c.	County of Death Baltimo	
Funeral Director		015 12 0507	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day APTIL I	4 ^{Year)} 1	9. Birti 20. 1nd	nplace (State or Foreign untry) Liana
faryland ehow	o.	Usual Residence of Decedent 10a. State 10b. County Md. Harfore		ty, Town or Lo	ration Forest	H:11				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the N 3a or 28e-	i Direct	10e. Street and Number 1877 Trudeau Driv	ve		10f. Zip Code	21050			zen of What Co	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if time 77 is marked other than "natural; or items 23a or 28e-f show eny injury or other traumatic event, the Medical Evaluar must be inclined at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1	I	Vas Decedent of Yes, specify Cul ☐ Yes 2 1 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:		1	14. Race - Amer Black, White	ican Indian,
in 72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give	ent's Usual Occu kind of work done	pation during most of worki	ng	16b. Kir	nd of Business/I	ndustry
1212 led with lygiene. her than	Comp		College (1-4or 5+)	ana1					. gover	nment
land lid be fi fental H rked off	To Be	17. Father's Name (First, Middle, Last) Robert Suver				18. Mother's Name Dorothy			Sumame)	
Maryland 21215-0036 and 2 should be filed within 72 hours aft allth and Mental Hygiene 127 is marked other than "natural", or traumatic event, the Medical Evan.		19a. Informant's Name/Relationship (Ty Eric Adams/son	pe, Print)			and Number or Rura Road, Sil				
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	sition (Name of latory or other pla Cremator	ce)			cation - City or T	
Baltil permit. 1 Departm Importa		21. Signature of Euperal Service License			Name and Address Schimune	ess of Facility Sk Funeral	Home o	f Be	1 Air,	Inc.
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deather cause on each line. Due to (or as a consequence)	Can	r the mode of dy	MacPhail R ng, such as cardiac o	r respiratory arr	est,	E, PICI.	Approximate Interval Between Onset and Death
Pu 15 15 15 15 15 15 15 15 15 15 15 15 15	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t							
Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥■No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3 □	Ectopic pregnanc Other (specify)	у		2:	3d. Date of deliv Month	ery Day Year
rds, P quires that n signed b	þ	Part II. Other significant conditions cor	tributing to death but not resi	ulting in the un	derlying cause gr	ven in Part I.		pacco us		the cause of death?
Record e law requii has been s pe 2 should	Completed						24a. Was a autops perform	y ned?	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
al Re		AP 151			04	26. Place of Death	(Check only on ne 5 ☐ Reside		ther (Specie	vlac Spice
of Vital Raysician: The nis certificate Pidirector, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No H	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA U	4 U Nursing Hon				P. District T. Links
on of Vital ing Physician: After this certifica uneral director.	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju. Wo	4 U Nursing Hon	8d. Describe ho			
ivision of Vital or Attending Physicien: ter death. trector: After this certifical n by the funeral director.	o Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specify	28b. Time of Injury	28c. Inju Wo M 1 =	y at 2 Yes 2 No	8d. Describe ho 8f. Location (St. City or Town	ow injury reet and r, State)	occurred Number or Rure	al Route Number,
ivision of Vital or Attending Physicien: ter death. trector: After this certifical n by the funeral director.	edical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Monner of Death 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	28b. Time of Injury	28c. Inju. Wo M 1 = et, factory, office	y at 2 k? Yes 2 No 2 me, date and place, a pinion, death occurre	8d. Describe ho	reet and n, State) ause(s) a ate and p	Number or Rura and manner as solace, and due to	tated. o the cause(s)
on of Vital ing Physician: After this certifica uneral director.	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Check only 2 Medical Examir	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify	28b. Time of Injury ome, farm, stre y) wledge, death tion and/or inve	28c. Inju. Wo M 1 Det, factory, office occurred at the tuesstigation, in my constigation, in my constigation.	y at 2 k? Yes 2 No 2 me, date and place, a pinion, death occurre	8f. Location (St. City or Town and due to the cad at the time, da	reet and o, State) ause(s) a ate and p	Number or Rura and manner as solace, and due to	tated. to the cause(s) Day, Year)

DHMH 17 Rev 1/2001

		·	1 - For State Registrar	State of	Marylan		artment rtificate			and M		Reg. No.	004	01170
	Dhyaisi		1. Decedent's Name (First, Middle,	Last)							Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medic		Wilson		cKinl	еу			ngto		Januar		2004	5:52PM
	Examir	er	4a. Fecility Name (If not institution,	give street and numb	oer)		4b. City, 1	Town, or	Location of	of Death		4c. Cour	nty of Death	
			Stage tealth co		A (1	de a de factorio de la co	If Under 1 Year If Under 24 Hrs.			24 Hre	0 D / Did		0.0145	
н	Funeral			6. Sex 7. 1 X ДM/2 □ F	Age (In yrs. 65	Yrs.	Months	Days	Hours	Min.	8. Date of Birl (Month, Da	y, Year)	9. Birthi	
	Director		220-36-5935 Usual Residence of Decedent		0,5						10 1	0 38		SC
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation			-			1	10d. Inside City Limits
	Mary	to	MD NA		B a	ltimo	re							1 X Yes 2 ☐ No
	1 the	rec	10e. Street and Number		110	L L LINC	10f. Zip	Code			T	10g. Citizen o	of What Cour	ntry?
	3e o	<u></u>	4614 Belvieu	Ave				2	1207			U	.S.A.	
	death	Funeral Director	11. Marital Status	12. Was Deced		.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		ace - Americ	cen Indian,
9	or Ite		1 ☐ Never Married 2 ☐ Marrie		™ No		1 ☐ Yes 2		Specify:	i, rueito	nican, etc.)		lack, White,	
21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "netural", or iteme 23e or 28a-f ehow event, the Medical Exartinar must be notified at	Completed by	3 ☐ Widowed 4 X Divorced	Year or Date	es:		1 1 1 1 0 3 2	22110	орвону.			Spec	В	lack
5	72 h netu	etec	15. Decedent's (Specify only highest	s Education grade completed)		(Give	dent's Usua kind of wor	k done d	luring mos	t of work	ng	16b. Kind of	Business/In	dustry
21	within ene. then	ld m	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>DO NOT u</i> s ocker	e retired)			Food	Serv	ices
2	filed with Hygiene. Ather ther		12th grade 17. Father's Name (First, Middle, L	na na			70.102		10 Mothe	do Nome	(First, Middle,			
ano	be fi	Be									•		arrie)	
yla	should be tand Mental I s marked o	ပ္	Wilson Arring			101 11 11					Harvey		. 0	0.41)
Maryland	C1 (0 -22 -		19a. Informant's Name/Relationsh								I Route Numbe			
	other tr		Sylvia Tucker 20a Method of Disposition	-Friend	20b P	4614 Place of Dispo			u Av		Baltim Date	ore Mo		. 207
Ö			1 X Burial 2 ☐ Cremation		ate	emetery, cre	matory or of	her plac						
Baltimore,	Department of mportant: If mportant: If any injury or once.		*4 □Donation 5 □Other (Sp		Ki						20/04	Randa.	llstc	wn, Md
3al	permit. P Departm Importar any inju		21. gn ture of Funeral Service L	censee		1	2. Name and 1arch	F/	H We	st				
	602 e a		MOKE D.	Justine	en'	- 1 . 1 2	1300	Wab	ash	Ave	Balt	imore	Md	21215
			23a. Pa. 1. Enter the disease, or c shock, or heart failure. List o	complications that cau inly one cause on eac	ised the deat th line.	n. Do not en	ter the mode	e of dylni	g, such as	cardiac (or respiratory ai	rrest,	,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a1	MYOCA	robal	into	wit	ion					1 hour
	/Medical Examiner		resulting in death)	Due to (or	as conseq	uence of):								
	LAGIIIII	_	Sequentially list conditions,	b. Due to (e.										
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ras a conseq	dence or):								
	and Ftran	хап	that initiated events resulting in death) Last	c. Due to (or	r as a conseq	uence of):								
60,	be executed sicien and burial-transit	E		1										
68760,	physicate Is the It	dlcal		d										
×	death certificate be executed attending physicien and of for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of nreans	ancy						224 6	Data of dallar	
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 ∏ Fete	death 3	Ectopic pre						Date of delive Month	Day Year
	t the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		eau Sc	_1 Other (Spe							
P.O.	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	inderlying ca	ause give	n in Part I.		23e. Did to	obacco use co	ontribute to ti	he cause of death?
ds,	signed be de	d by									10	res 2□No	3 Prob	pably 4 Dunknown
Records,	w requir been s should	Completed									24a, Was	041	- Wess subs	and findings sucilable
3ec	has pe 2	Id II									autor		prior to co death?	ppsy findings available mpletion of cause of
al F	cate ha										1 □ Yes	2⊠No		2□ No
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to	d is	은	1 ☐ Yes 2 ☑ No 27. Mannel of Death	1 Inp		ER/Outpaties 28b. Time of		A Bc. Injury	4 🗀 140	-	me 5 Residence 1			(y)
	fter	Certification:	1 ☑Natural 5 ☐ Pending		Day Year)	Injury	M	Work	al (? (es 2 □ !		zou. Describe i	iow injury occ	arrea	
Division	Attending in death. ector: Attention by the fune	cat	2 Accident investigation in Accident in Accident	ot be 380 Place o	f Injury - At ho	omo form et			103 20	_	28f Location /	Street and Nur	nher or Rus	al Route Number,
N.	i Sign	i i	4 Homicide determin	ned 200. Place of building	, etc. (Specif	y)	reet, factory	, omce			City or Tox	vn, State)	noer or mare	i nodie ivalliber,
	the Hospital or Attennin 24 hours after deat the Funeral Director: Apletely filled in by the		29a. Certifier 1 Certifying	Physician: To the b	act of my kno	udodae deet	th oppured t	at the tim	o data an	d place	and due to the	causa(s) and	mannor ac c	tatad
	Hos 24 hc Fun Fun	Medical		xaminer: On the bas and manne	is of examina									
	To the Hospital or Attendi Within 24 hours after death. Ta the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	end maille			29c	. License	number			29d. Date sign	ned (Month.	Day, Year)
	- 8		ha to	Com -				047	353		1			3,2004
	1		20 Name and discrete	the completed	of death (tre-	n 23c) /7:							7	
-	0		30. Name and address of person v	C 0	of death (Item	n 23a) (Туре, Avem	rint)	Balt	MORE	M	aryland	217	229	
		ate	31. Date filed (Month, Day, Year)		gistrar Signa	ature .			***	1.	ary land			
	Regist		JAN	1 2 1 4UU4	Medi	w si	· And	BASE	,					

THE JOHN ARRINGTON WIZLSON

			For Stete Registrar		Marylan	d / Depa		of H	ealth a				2004	0 1 7 1	
	Physici /Medic	al	Decedent's Neme (First, Middle, La Dorothy M. Atki: Facility Name (If not institution, give	ns	ber)		4b. City, T	own, or	Location o		2. Date of D Month Januar	р 12,	Year 2004 County of Dee	3. Time of Death 6:45 A M	
	Examin Funeral	er	4818 King Avenu	е	7. Age (In yrs. 76	last birthday) Yrs.	Balt If Under 1	imo:			8. Date of Bi (Month, D 7/8/1	Baltimore irth ay, Year) 927 Birthplece (State or Foreign Country) Maryland			
	Director Month		216-20-3969 Usuel Residence of Decedent 10a. State 10b. County			y, Town or Lo					77071	.921	ria	10d. Inside City Limits 1 Yes 2X No	
	with the Ma 3s or 28s-f	il Director	MD Balt 10e. Street and Number 4818 King Avenue	imore		more 10f. Zip (10f. Zip Code 21236					10g. Citizen of What Country? U.S.A.			
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, It a Mie Jical Examiner must be rediffied at or other traumatic event, It a Mie Jical Examiner must be rediffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 21☐ No			Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:					0- 1	4. Race - Am Black, Whi		
Baltimore, Maryland 21215-0036	d within 72 ho giene. Ir than "natur It e Me Jical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-	4or 5+)	(Give	Decedent's Usual Occupation Give kind of work done during most of working ifie. DO NOT use retired) omemaker					16b. Kind of Business/Industry Domestic			
ryland	hould be file id Mental Hyg marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last Raymond R. Gayh 19a. Informant's Name/Relationship	Dor	othy	Fromm		Sumame) Town, State,	Zip Code)						
ore, Ma	jes 1 and 2 st of Health and If item 27 Is n or other traun	1 Burial 25 Cremation 3 Removal from State cemetery, crematory or other place)									Mary1	ryland 21236 c. Location - City or Town, State			
Baltim	permit. Peges 1 an Department of Heal Important: If item 2 any injury or other 2002.		Balto./Wash. Crematory 1/17/04 Laurel, Mar 21. Sign rure of Foreral Service Licenses 22. Name and Address of Facility Miller-Dippel Funera 6415 Belair Road Baltimore, Maryland 23a. Part! Enter the disease, of complications that the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pach line.										al Home Inc.		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. 500 (OTE of as a conseq	uence of	er the mode	of dying	fuc fuc D	cardiac o	respiratory: White EAS	arrest, L	2)	Approximate Interval Between Onset and Death A Jon Ins	
3760,	tificate be executed by physicien and as the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	quence of):											
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					2	elivery Day Year				
ords, P.	w requires that been signed b should be deta	ted by P	/ / / /	adifn	_		nderlying ca	use give	en in Part I.			tobacco us		o the cause of death? robably 4 @Onknown	
of Vital Records,	in: The law inficate has bor, page 2 sh	e Completed by	25. Was case referred to medical	ARRYTHANA 26. Place of Death (C)						perl 1 Tes	opsy formed? 2DNo	prior to death?	utopsy findings available completion of cause of s 2 No		
ion of Vi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	To B	examiner? 1 Yes 2 No 27. Manney of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date o (Monti		ER/Outpatier 28b. Time o Injury		c. Injury Work	er: 4□ Nu	rsing Ho	/	sidence 6	Other (Spe	ecify)	
Division	Hospital or Atte 24 hours after de Funerel Directo tely filled in by th	i Certification:	3 Suicide 6 Could not lead to determine determined	buildir	of Injury - At hig, etc. (Specif	(y) 			o data sa		City or To	own, State)		tural Route Number,	
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier Gertifying P (Check only onle) 2 Medical Exe	miner: On the ba	sis of examina	ation and/or in	vestigation,	in my or	oinion, dea	th occurr	ed at the time	, date and	place, and du	th, Day, Year)	
	10		30. Name and address of person who	completed caus	e of death (liter	123a) (Type,	Print)	13(5;	302	7	OWS	1/ 50N	por	neod	
9	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 1 20		egistrar's Signa	ature	ويمله					-			

			For	State of Marylar		artment of H			<u></u>	004	01172
			Registrar 1. Decedent's Name (First, Middle, L	as#	Ce	runcate or L	Jean	2. Date of Dea	Reg. No.		3. Time of Death
П	Physici		David	Bouche	-			Month	Day	Year.	0300 4
	/Medio Examin		4a. Facility Name (If not institution, g		Wosp.Ta	4b. City, Town, or	Location of Dea	Ci+y		ty of Death	
	Funeral Director		5. Social Security Number 6. 214-64-7511 Usual Residence of Decedent	Sex 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		r, Year)	Coun	lace (State or Foreign try) yland
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	0d. Inside City Limits
	Mary B-f eh	tor	MD Carro	11		Hampst	ead				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
	s 23a	ral		dland Court	10 10		21074	2000 # W No		.S.A.	on Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28e-f ehow any injury or other treumatic event, Ita Medical Examinar must be notified at ODGE.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2점 No		rto Rican, etc.)	Spec	ack, White,	
Maryland 21215-0036	72 hor	Completed	15. Decedent's (Specify only highest of	Education trade completed)	(Give	dent's Usual Occupa kind of work done d	uring most of w	orkina	16b. Kind of	Business/Ind	lustry
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			Collabor		T 0
, q	Hygie ther t int, th	CO	17. Father's Name (First, Middle, Las	st)		Owner	18. Mother's Na	ame (First, Middle,	Goldkee Maiden Suma		inc.
ano	id be in the in	To Be			cher			gina		Bunty	
ary	shouland Mark	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	nd Number or F	Rural Route Numbe	r, City or Tow	n, State, Zip	Code)
Σ	and 2 salth an 27 is		Kimberly L. Bouc		- Committee of the Comm	Woodlawn	Court	Hampstead			
Baltimore,	Pages 1 nent of Ho ent: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3		Place of Dispo cemetery, crea	sition (Name of matory or other place	9)	Date	20c. Location	- City or To	wn, State
Ë	rtmen rtent: njury		* 4 □ Donation 5 □ Other (Spec	city) Cai		Cremation				stead	·
Bai	Depa Depa Impo any iu		21. Signature of Funeral Service Lic	MALL		2. Name and Addres Eline Fune		11824 Re			
	_		23a. Part1. Enter the disease, or co	mplications that caused the dear						, FID 2	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on each line. Mult	iple	Tolux	pe i	Compli	catio	ns	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		0	113	O. A. J. L.			
В	Examiner		Sequentially list conditions,	b				CERTIFICATION APPRO	9		
9	led Isit	nlne	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	(uanca UI):			0	XM	MINER	
	execun n and al-trai	Examiner	that initiated events resulting in death) Last	c	quence of):			$\overline{}$	MEDICA	EKAM	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	edical		d				De PORO	VED BY "		
9	rtificat ng phy as th	Medi	IS SERVICE .				-	TIFE TION AT			
Вох	eath certific attending p I for use as I	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnative birth 2 ☐ Feta	eldeath 3[Ectopic pregnancy		CERII.	23d. D	ate of deliver	ry Day Year
0.		Physiclan/M	1 Yes 2 No	4 ☐ Pregnant at time of o	death 5	Other (specify)				TOTAL T	ou, rou
<u>a</u>	requires that the de neen signed by the a hould be detached f		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use co	ntribute to the	e cause of death?
Vital Records,	w requires that s been signed to should be deta	d by						1 □ Y	es 2□No	3 🗌 Proba	ably 4 Dunknown
Ö	law rec as bee	olete						24a. Was a		. Were autop	sy findings available
æ	The la ate ha	Completed						autops perfor		death?	pletion of cause of
/ita	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?					eath (Check only or	•		
of <	Physician: this certific ral director,	္	1≱Yes 2□No	1000	ER/Outpatier		4 Li Huising	Home 5 Resid)
uo.	ding F	lon	27. Manner of Death 1 □ Natural 5 □ Pending 25€ Accident investigate	28a. Date of Injury (Mon h, Day Year)	28b. Time o Injury	✓ Work	?	Driver	Ska	irred (de
Division	Attsnding r death. sctor: After by the fune	flca	3 Suicide 6 Could not	be 28e. Place of Injuly - At h	ome, farm, sti			28f. Location (S	treet and Nun	ber or Rural	
ă	s after of Dire	Certification:	4 Homicide	building, etc. (Special	way			Black R	OCK t	292	onr Grace
	To the Hospitel or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying I	hysician: To the best of my kno aminer: On the basis of examina	owledge, deat	h occurred at the time	e, date and plac	e, and due to the c	ause(s) and n	nanner as sta	ated.
	the H hin 24 the F nplete	Medi	one)	and manner stated.		29c. License					
)	To Cor		29b. Signature and title of certified						29d. Date sign	-2	
			30. Name and address of person wh	o completed cause of death /Itel	m 23a) (Tyne	Print)	2 /		, 500		
	15		NHARAST	tz 225	· doge	Print) ene St	recit				
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature da	refer					

		Registrar	State of Maryla		Certificate of	Death	Re	g. No.	7 0 1 1 1
Physicia /Medic	al	Decedent's Name (First, Middle, Last)	Reginald	S.			2. Date of Death Month	Day H Year	148,407 W
Examine Funeral Director	er	4a. Facility Name (If not institution, give since the security Number 228-34-1506	7. Age (In)	rs. last t	1 (5/2		rs. 8. Date of Birth	4c. County of De 17 n n 9. Bi	rthplace (State or Foreign Country VA.
0		Usual Residence of Decedent 10a. State 10b. County			wn or Location	Passadena			10d. Inside City Limits
with the Ma 3a or 28a-f s	i Director	Maryland Anne At 10e. Street and Number 8331 Catherine Ave	10	g. Citizen of What C	1 Yes 2 No				
urs a	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 □X'es 2 □ No If Yes, Give Year or Dates:	1953 1954	13. Was Decedent of If Yes, specify Cu		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
d within 72 ho giene. ir then "naturi ine Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16	a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir Ma	e during most of w	vorking 1	6b. Kind of Busines: Telep	s/Industry hone Co.
should be filed and Mental Hyge marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Thomas	Beverley			18. Mother's N	lame (First, Middle, M Ren	laiden Sumame) olqo Camp	16.0
and 2 sho ealth and m 27 is ma		19a. Informant's Name/Relationship (Typ Lillian Beverly Wife	e, Print)	19	b. Mailing Address (Stree 8331 Cather	ne Ave Pas	Rural Route Number, sadena, Maryla	City or Town, State, nd 21122	Zip Code)
Pages 1 ment of He ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 3 ☐ Other (Specify)		cemet	of Disposition (Name of ery, crematory or other po Crownville Veteria		Date 2 01/20/04	0c. Location - City o	r Town, State sville,Md.
Departic Imports any inju		21. Signature of Funetial Service License	11		22. Name and Add Estep 1300	ress of Facility Brothers Fu Eutaw Place	neral Home P. Baltimore, M.	A. 21217	
In the law requires that the death certificate be executed the has been signed by the attending physician and be detached for use as the buriat-transit bage 2 should be detached for use as the buriat-transit bage 2.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Errie underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a con: Due to (or as a con: Due to (or as a con:	sequence	e of):				Onset and Death
y the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal deal	h 3 Ectopic pregnan 5 Other (specify)	су		23d. Date of de Month	blivery Day Year
been signed by the should be detached	by	Part II. Other significant conditions conf	ributing to death but not	ng to death but not resulting in the underlying cause given				_	to the cause of death?
certificate has bee	e Completed	25. Was case referred to medical	<i>O</i> 1					ed? prior to death? ☐ Ye.	utopsy findings available completion of cause of s 25 No
ih is	ToB	examiner?	ospital: 1∰Inpatient 2 28a. Date of Injury (Month, Day Year	28b.	Time of 28c. Injury W	ther: 4 \(\sum \) Nursing	Home 5 Resider 28d. Describe how	nce 6 Other (Spe	acify)
s after death. al Director: After ed in by the funer	Certification:	3 Duicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	At home, ecify)	arm, street, factory, office	•	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
within 24 hours after To the Funeral Directory (Completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledg nination a	ge, death occurred at the nd/or investigation, in my	time, date and pla opinion, death oc	ce, and due to the car curred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To t	M	29b. Signature and title of certifier	7 m)	h 5-	24	S VO (29	d. Date signed (Mon	th, Day, Year) 14th, ZW
' \		30. Name and address of person who cor	npleted cause of death (Item 23a	(Type, Print)	26	(= -	R	1 mn 7 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1535 M **Physician** 00 2004 mare 8161A /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner Silver RV 15 Omer Glenallen 2603 8. Date of Birth (Month, Day, Year April 28, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Year) **Funeral** Hours Min 1 ☐ M 2 🔽 F 62 Yrs. Virginia 230-52-4774 1941 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28e-f show doer rount be notified at 1 ☐ Yes 2X No Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ USA 20906 Items 23a 2603 Glen Allen Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other treumatic event, the Madical Examilia. 1 ☐ Yes 2 ☐ MNo If Yes, Give Year or Dates: Never Married 2 ☐ Marned 1 ☐ Yes 2 【XNo Baltimore, Maryland 21215-0036 Specify Black. 3 Widowed 4 Divorced 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Howard University Administrative Assistant 4+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Christine P. Allen Kenneth R. Bowles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 940 Rockcreek Rd., Charlottesville, VA 22903 Michelle Allen - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Charlottesville, VA Oakwood Cemetery *4 □ Donation 5 □ Other (Specify) 1/17/04 21. Signature of Funeral Service License 22. Name and Address of Facility.
J.F. Bell Funeral Home 23a. Part. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Inherent Hom 108 Sixth Street NW Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited disease or condition resulting in death) 108 Sixth Street NW Charlottesville, VA Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseque Examiner t or Attending Physicien: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and e n r as a consequence of) physician a Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. P detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ď 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospitel within 24 hours at To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00428 2004 cus . DME

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/0/

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32. Registrar's Fignature

RA N BRECHER

31. Date filed (Month, Day, Year)

		1_ State	partment of Health and Mertificate of Death	ental Hygie	ene 2004	0 1 75	
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	stillcate of Death	2. Date of Death	. No.	3. Time of Death	
Physicia /Medic		Decedent's Name (First, Middle, Last) Edward J.	Brzezinski	January	Day 19, 2004	2:15 A M	
Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
		7311 Manchester Road	Dundalk		Baltimore		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-01-6768 7. Age (In yrs. last birthday) 95 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y February	9. Birthp 24-1908	lace (State or Foreign try) MD_	
		Usuel Residence of Decedent				PID.	
ylanc		10a. State 10b. County 10c. City, Town or			1	0d. Inside City Limits	
a-fal	ior	MD. Baltimore Dund	alk			1 ☐ Yes 2 🛣 No	
If it is within 72 hours after death with the Maryland Hygione. Hygione. The than "natural; or Items 23a or 28a-f show ont, the Macilical Examiner must be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Coun	try?	
23a	rail	7311 Manchester Road	21222		USA		
r de s	rue		 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	te	
72 hours "natural",			edent's Usual Occupation	16	6b. Kind of Business/Inc	fustry	
be filed within 72 ho ntal Hygiene. nd other then "natu	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	ng	,	,	
with	E O	Elementary/Secondary (0-12) College (1-4or 5+)	ographer		Printing		
Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	uiden Sumame)		
Ald be Alenta rked tlc ev	To B	Joseph Brzezinski	Josephir	ne Frisch	ו		
12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, tre Men	ľ		ling Address (Street and Number or Rura		•	Code)	
and and m 27			Manchester Road, I				
ges 1		1 Burial 2 Micromation 3 Hemoval from State	ematory or other place) Janua	ary	c. Location - City or To		
it. Pa ritmen ritmit: njury			Crematory 22, 2		altimore Ci	ty,MD.	
permit. Pages 1 and 2 should be permit. Pages 1 and 2 should be permean of the atths and Menta Important: If item 27 is marked any injury or other traumatte any one.		apathony Connecy	Connelly Funeral Ho 7110 Sollers Point	Road, Du	ndalk, MD.	21222	
	6	23a. Part I. Enter the disease, or complications that caused the death. on the shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arres	t,	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	12 Myon of	4		Onset and Death	
/Medical Examiner		resulting in death) Due to (or as a consequence of):	1	1		, , ,	
Examine:	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
) sit	Examiner	cause. Enter Underlying Cause (Disease or injury					
be executed ician and burial-transit	xar	that initiated events c			-		
	m	C _d					
tificat g phy as th	ledi						
th cert	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery		
he att	Physician/Medic		Other (specify)		Month	Day Year	
d by t	Phy	Part II. Other significent conditions contributing to death but not resulting in the	underhing cause given in Part I	23e Did toba	cco use contribute to th	e cause of death?	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely illied in by the funeral director, page 2 should be detached for use as the	d by	PAIL II. Other significent containers continuing to death out for resulting in the	underlying cause given in Fact.		2 □No 3 □ Prob		
w req	jete			24a. Was an	24b. Were auto	osy findings available	
The la le has age 2	Completed			autopsy performe 1 Yes 2	ed? death?	npletion of cause of 2□ No	
an:] tifica	a a	25. Was case referred to medical	26. Place of Death		2140	20110	
ysici is ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpate	ent 3 DOA Other: 4 Nursing Hor	ne 5 Nesideno	ce 6 □Other (Specify)	
ng Phy Iter this		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury		28d. Describe how	injury occurred		
endir oath. he fu	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	I Route Number,	
pital ours a eral [29a. Certifier 12 Certifying Physicien: To the best of my knowledge, de-	ath occurred at the time, date and place a	and due to the cau	sp(s) and manner as et	atod	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.					
To th withir To th comp	ž	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, I	Day, Year)	
0		MI	12 2 379	\	1500	4	
4		30. Name and address of person who completed cause of death (Item 23a) (Typ	and the second s	0177	ar Mil	21221	
		SAVITHA SHIVANANDA [12] 31. Date filed (Month, Day, Year) 32. Regignar's Signature	+ MACE AVE B	"U LITHO	RE MO	X 189	
Sta Regista		JAN 2 1 2004	breste)				
			And Parket States				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5.10 PM AL FRED BATLEY JAN 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LAUNEL PRINCE GOVEGE LAURGIREZIONAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** March 8, 1923 Marvland Director 224-28-4907 80 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show ns 23a or 28e-f shov 1 Yes 2 No Prince Georges Maryland Directo College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4203 Metzerott Road U.S.A 20740 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ŏ If Yes, Give Year or Dates: 1945-46 Specify: ģ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Metro System Bus Driver/Mechanic Pages 1 and 2 should be filed withment of Health and Mental Hygientent: If Item 27 Is marked other thiury or other treumatic event, Instituty or other treumatic event. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henry Bailey Estella Florence Bambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathrine Bailey (Wife) 4203 Metzerott Road, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or one *4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Ft. Lincoln Cemetery 1/17/2004 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Functial Service Licensee MO1250 7601 Sandy Spring Rd, Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STREPTOWCKAL PNEUMONIA **Physician** ZWEEKS /Medical Due to (or as a consequence of): Examiner S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year ģ Month Day 4 Pregnant at time of death P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by MUN SMALL CELL LING CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed CINZOWIC UBSTRUCTIVE PULMOWHAY 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? MALNUTRITION PROTEIN 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 - ER/Outpatient 3 - DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 💢 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N36974 JAN 13, 2004-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE MATURISMT PARTICUMY, COLUMBIA OM MOTHAYN. O CHAND MD 21044 32. Registrar's Synature 31. Date filed (Month, Day, Year) State 2004 Registrar

		1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and rtificate of Death	Reg. N	- 211111	0117
hysicia	20	1. Decedent's Name (First, Middle, Last		11.	2. Date of Death Month	Day Yeer	3. Time of Death
/Medic		Edward VOHN	Borkows			2 2004	21:10
Examin	er	4a. Fecility Name (If not institution, give University of Maryland		4b. City, Town, or Location of Dea Bathmore		N/A	
uneral rector		5. Social Security Number 6. Se X	x 7. Age (In yrs. last birthday, 71 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthp Coun 932 MARYL	lece (State or Fore try) AND
>		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Lim
sho	20					,	1 □ Yes XXI
288-	Director	MARYLAND BALTIMORI 10e. Street and Number	E BALTIMORI	10f. Zip Code	10g. C	Citizen of What Coun	itry?
r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at	0	3310 BENSON AVENUE	E. APT. 403	21227		TED STATE	S
E UNITED	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - Americ Black, White,	
or ite	F	1 Never Married XX Married	Armed Forces? NOTYes 2 No 1950- NY Ses, Give 1953	1 ☐ Yes 2 X No Specify:	nto riibari, etc.,	Specify:	etc.
ural',	d by	3 Widowed 4 Divorced	teal of Dates.			WHI	
Tage of the second	Completed	15. Decedent's Edu (Specify only highest grad	le completed) 16a. Dece (Give	edent's Usual Occupation B kind of work done during most of wo DO NOT use retired)	orking 16b.	Kind of Business/Inc	dustry
th and	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	RPENTER		LDING	
d other event, II		17. Father's Name (First, Middle, Last)	- OAI		ame (First, Middle, Maide		
D .	To Be	JOHN BORKOWSKI		MARY KL	ONOWSKI		
item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Maili	ing Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip	Code) 2122
er tra		ADA L. BORKOWSKI	(WIFE) 3310	BENSON AVENUE, A	PT. 403; BA	ALTIMORE,	
r othe		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ [20b. Place of Disposementary, cre		Date 20c. 16,	Location - City or To	wn, State
ant: If ury or		*4 □ Donation 5 □ Other (Specify)		ARK CEMETERY 200		LTIMORE. 1	MARYLAND
Important: If its any injury or o once.		21. Signature of Funeral Service Licens	2	2. Name and Address of Facility LO	UDON PARK F 20 WILKENS	UNERAL HON	ME
E # 9		X XXIII (CIII) all	7,	BA	LTIMORE, MA	RYLAND 21:	229
sician edical miner	Examiner	Immédiate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	infarction			Onset and Death
ed by the attending physician and detached for use as the burial-transit	cai	IF FFMALE:	d			23d. Date of delive	ry
y the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Day Year
should be deta	by PI	Part II. Other significant conditions co	ntributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
an sig	ed t				1 ☐ Yes	2 □ No 3 □ Proba	ably 4 ₩Unknov
2 sho	Completed				24a. Was an	24b. Were autop	sy findings availab
page 2	ШО				autopsy performed? 1 ☐ Yes 2 ☒ N	death?	npletion of cause o 2□ No
certificate ector, pag	BeC	25. Was case referred to medical		26. Place of De	eath (Check only one)	1 103	20110
s E	ToE	examiner?	Hospital: 1 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify	')
After th funeral	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \) No	28d. Describe how inj	ury occurred	
I Director: d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural ite)	l Route Number,
	Medical (29a. Certifying Phy (Check only one)	sician: To the best of my knowledge, deal ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place average in the street of the street at the str	e, and due to the cause(curred at the time, date a	s) and manner as stand place, and due to	ated. the cause(s)
e Funera etely fille				29c. License number	29d. D	ate signed (Month, L	Day, Year)
to the Funera	Me	29b. Signature and title of certifier					
To the Funera completely fille	Me	29b. Signature and title of certifier AUAU	WON MD	P17708	10	in. 12, 2	2004
To the Funeral Director: After thi	Me	Herai Ke	OMON MD OMPleted cause of death (Item 23a) (Type, 27 Sowth Greene. St	, Print)	<u>_</u>	in. 12, 2	2004

			1 - For State Registrar	State of I	Marylan		artmen rtificate			and M		giene g	2004	01178
	Discostati		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Lydia	Bagwe11							Januar	y 17,	2004	3:00a M
	Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City,	Town, or	Location o	of Death		4c. Cc	ounty of Death	
4			Villa St. Mic	hael			Balt						N/	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F		last birthday)	If Under Months		If Under:	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Ye <i>ar</i>)	9. Birthr	place (State or Foreign
	Director		212-22-0941	10 W 2 M L	92	Yrs.					(Month, Day Aug. 2	, 191	l Nort	h Carolina
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y. Town or Lo	cation						1.	0d. Inside City Limits
	sho	ō	Maryland N/A			ltimor								12 Yes 2 No
	28e-1	ect	10e. Street and Number		ра	TLIHOT	10f. Zip	Code				10a Citizer	n of What Cou	atry?
	with	ក់	3529 Rockdale	Ct				2124	. Д			-	d Stat	_
	eath	erai	11. Marital Status	12. Was Decede	nt Ever in U	S 13 V				nin? (Sne	acify Yes or No-		Race - Americ	
36	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumatic event, the Medical Examiner must be multified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	Armed Force	s? ∑No		f Yes, spec		Specify:	i, Puerto	ecify Yes or No- Rican, etc.)	1	Black, White,	
21215-0036	tura al E	ed	15. Decedent			16a, Deced	dent's Usua	I Occupa	tion			16b. Kind	of Business/In	
5	in 72 n "na	Completed	(Specify only highes	t grade completed)		(Give	kind of wor DO NOT us	rk done d	urina most	t of worki	ing	100. 14.110	0. 00311030411	333119
5	than than	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Ow	ner					Rest	taurant	
Ö	e filed al Hygie other vent,	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden Su	mame)	
an	Mental Merked o	To B	John	н. н	Brown				Ze]	lda			Lovick	
Maryland	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	al Route Numbe	r, City or To	own, State, Zip	Code)
	and 2 salth a n 27 is		Minnie Hargrow	(Sister)		3529	Rock	dale	Ct.	Bal	ltimore	MD 2	21244	
ē,	s 1 and the Healitern 2		20a. Method of Disposition		20b. P	lace of Dispo					Date		tion - City or To	wn, State
E	2 2 E D		1 🖾 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (S)		Lou	ıdon Pa	ark Ce	emete	erv 1	1/24/	/04	Balt	imore	Maryland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service			Lo Lo	. Name and	Addres	s of Facility	y eral	Home			10
			23a Part1. Enter the disease, or	complications that caus	sed the death	h. Do not ent	ozU Wi	LIKer	IS AV	enue cardiac c	, Balti or respiratory ar	more,	Maryla	and 21229 Approximate
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	s a consequ	ble	Av	5	in	a				Interval Between Onset and Death
the .	Lxammer	_	Sequentially list conditions, if any, leading to immediate	b. Hy	per	ten	Solo	000						
,	ed isit	Examiner	cause. Enter underlying Cause (Disease or injury	Due to (on	as a consequ	uence or):								
_	ate be executed hysician and he burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
3760,	be ei ician buria	caiE												
687	phys the			d										
.O. Box (v requires that the death certifical been signed by the attending ph) should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown								23d. Date of d Month			ory Day Year
<u>α</u>	The law requires that the tee by the bas been signed by the bage 2 should be detache	y P	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to th	e cause of death?
gp	uires sigr id be	d by	Decen	ratio	e To	Sint	-	Sex	200		1 🗆 Y	es 2 🗆 N	lo 3∏Prob	ably 4 Unknown
Records,	w requir	Completed	3		J				0		24a. Was a	2	Ab Wore auto	psy findings available
Re	: The law cate has l	m d									autop: perfor	sy med2	prior to con death?	inpletion of cause of
a			OF Man area referred to medical									2 🗷 No	1 🗆 Yes	2.2 No
Vital		Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		55/0:		Othe			(Check only or			
of	Phys rthis raldi	7:	1 Yes 2 No	28a. Date of li		ER/Outpatien 28b. Time of		Bc. Injury	4 NU		me 5 Resid			/)
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isi	Attendideath.	fica	3 Suicide 6 Could r	not be and Blace of	Injury - At ho	ome, farm, str					28f. Location (S	treet and N	umber or Rura	l Route Number,
<u>S</u>	s after 9i Dire 9d in b	Certification:	4 Homicide	building,	etc. (Specify	y)	,				City or Tow	n, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the be Examiner: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the c ed at the time, o	ause(s) and late and pla	d manner as st ace, and due to	ated. the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier				29c.	License	number		2	29d. Date si	gned (Month,	Day, Year)
	h ,		Wille B	25-	7,11	rd)	1	17	42	-		1/21	104	
	1		30. Name and address of person		f death (Item		Print)	e A	ال ال	مانتا	Wille .	1 7	212	77
_6	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's igna		-		_		- V. 11(-10	
1	Registr	ar	JA	N 2 1 2004	Mesu	an B	do	Carried .	7					
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ORIGINAL

		For State Registrar	State of Mary		epartment of H Certificate of L			leg. No.	04	01179
Physici		1. Decedent's Name (First, Middle, Las	Clifford	Jay	Bennett		2. Date of Dea Month Januar	Day	Year 004	3. Time of Death 11:15 PM
/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County		
LXaiiiii	iei	2510 Ruth Avenue			Edgeme	ere		Bal	timo:	re
Funeral		Social Security Number 6. S		n yrs. last birthe	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lece (State or Foreign
Director		213-68-7994	ØM 2□F 4.	7 Yr	s. Norths Days	110010	July 6,	1956	Ma	ryland
Pu »		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town o	or Location		·		1	0d. Inside City Limits
aryla shov	-			oc. Ony, Town	Location					1 ☐ Yes 2 ☒ No
Ba-f	octo		ltimore		10/ 7: 0-4-	Ec	dgemere	I Og. Citizen of V	Afhat Cour	stn/2
with the	Ē	10e. Street and Number			10f. Zip Code	21219		Unite		•
036 burs after death with the Marylan set, or items 23e or 28e f show Efaith we trinke be notified at	by Funeral Director	2510 Ruth Avenu	12. Was Decedent Eve	er in II S	13 Was Decedent of H		acify Yes or No-			an Indian,
ter de Item	Š	11. Marital Status 1 ☐ Never Ma <i>rr</i> ied 2€ Married	Armed Forces?	31 III 0.5.	 Was Decedent of Health of Yes, specify Cuba 	in, Mexican, Puerto	Rican, etc.)	Blac	ck, White,	
36 irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 22CMNo	Specify:		Specify	" Wh	ite
d 21215-0036 filed within 72 hours after death with the Maryland hygiene. ther then "natural", or froms 23e or 28e-f show int, the Medical Exant. writing Les modified at	bed	15. Decedent's Ed	ducation	16a. D	ecedent's Usual Occup	ation		16b. Kind of B	usiness/In	dustry
215 7 nic 7	Completed	(Specify only highest gra	College (1-4or 5+)		Give kind of work done of the contract of the	during most or workii f)	ng			
d 2121 filed within Hygiene. other then	Eo	9 Years	50110g5 (1 451 5 1)	Hea	vy Equipmer	nt Operato	or	C.J.	Lang	enfelder
al Hyg	3e (17. Father's Name (First, Middle, Last)				18. Mother's Name			10)	
arylan should be nd Mental marked d	To Be	Daniel Bennett					Bessie	Leevy		
	1	19a. Informant's Name/Relationship (19b. A	Mailing Address (Street	and Number or Rura	il Route Numbe	r, City or Town,	State, Zip	Code)
e, M		Mrs. Catherine			510 Ruth Av		nere, Ma		212	
		20a. Method of Disposition **XXBurial 2			Disposition (Name of crematory or other place		Date	20c. Location -		
Pages ment of ant: If it ury or o		*4 □ Donation 5 □ Other (Specific	y) 1	Sacred	Ht. of Jesu		-		ndalk	
Baltime Permit. Pag Department Important: In sny injury o		21. Signature of Juveral Service Licer	y Y		22. Name and Address Duda – Ruck	Funeral F	Home of	Dundal	k, In	c.
		1 121/111	July	10	7922 Wise	Ave. Dur	ndalk, N	Maryland	1 21	222 Approximate
		23a. Part1. Enter the disease, or com shock, or heart failure. List only				g, such as cardiac d	or respiratory ari	est,		Interval Between Onset and Death
Pnysician		Immediate Cause (Final disease or condition	a 6/10	plast	umc-					15 mosths
/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
<u> </u>	L	Sequentially list conditions,	b	the student of						
O De la la la la la la la la la la la la la	line	Sequentially list conditions, if any, reading to infine diate cause. Enter Undertying Cause (Disease or injury	Due to (or se a c	oneaquence or						
and I-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of);					
\$8760, real physicien and sthe burial-transit										
Phys s the	edical		_ d							
Box 6 Box 6 eath certifications attending for use as	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		_			23d. Da	te of delive	ery
atte eath	ciar	in the past 12 months?	1□Live birth 2 [4□Pregnant at tirr		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	′		Mo	enth	Day Year
Records, P.O. Box The law requires that the death certified has been signed by the attending page 2 should be detached for use a	Physician/M	9 Unknown	9 Unknown							
S that	by P	Part II. Other significant conditions of	contributing to death but r	not resulting in t	he underlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
rds,							1 🗆 Y	es 2□No	3 Prob	ably 4 Unknown
aw requir	ompleted						24a. Was autop		Were auto	psy findings available mpletion of cause of
I Re I Re The lay	E						perfor	med?	death?	•
	C	25. Was case referred to medical				26. Place of Death		7		
Physician: this certificated director.	0 8	examiner? 1 ☐ Yes 2 ☐ Ño	Hospital: 1 Inpatient	2 ER/Outp	patient 3 DOA Oth	er: 4 Nursing Ho	me 5 Resid	ence 6 X Oth	er (Specif	n Houns a
On On Oling Ph	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Tir	ne of 28c. Injur	y at k?	28d. Describe h	ow injury occur	red	
Sion thending death.	atio	1 Natural 5 Pending investigatio	n			Yes 2 □ No				
Divis of or Atternated after des I Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (n, street, factory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
Di ital or us afte	Cer									
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai	(Check only 2 Medical Example 12	nysician: To the best of miner: On the basis of ex	xamination and/						
thin 2 the the mple	Med	29b. Signature and title of certifier	and manner state	d.	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
T with	_	Dirol	/		1770	321		11/1/	14	
		- rung 1	completed cause of dea	th /Item 22a) /T	una Print)	<u> </u>		1/0/	-	
5		30. Name and address of person who	(Pri)	1 N. 7	ntaw St.	Bul	Homes 1	Mdala	01	
St	ate	31. Date filed (Month, Day, Year)	32 Aegistrar's	s Signature	1					
Regist		JAN CI (104	3 25 1	JOHN J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 per fh 8845 /-15-05 vt

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 23a per Dr., G827, 01/21/0 dib
Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ellami Month 2:20 AM iam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manore are BAILMURE aneu If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) June 14, 1939 Yrs. Director NICI Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or Items 23a or 28a-1 show 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Completed by Funeral Director Yes 2 No BAILMURE M.D 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5261 15.A Coad 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates: ARMY 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 4 Married Baltimore, Maryland 21215-0036 Specify: BIACK 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCK DEIVER and Mental Hygier is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Pages 1 and 2 should be Sut BEILAMY ٩ Shidey CURNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) item 27 la 21206 5261 Cedgate BAILIMOR MD Bell Amy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of the Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State National MANIAND SAUREL MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEHS Funeral Jahrera Dexts CARSINE 54 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ₽₩nknown 24a. Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? 1 Yes 2 1 No of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 ANatural 5 Pending within 24 hours after death. To the Funerel Director: A М 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO054424 1-13-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, MD Suite 205 ZiP code: 21204 Asadi Cyrus 7600 Osler Dr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death JANUARY **Physician** ALMA BROOKS 1245 2004 16 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL CENTER RANDALLSTOWN BALTIMORE NORTH WEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 Z F 76 Yrs. MD Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natursi", or items 23s or 28s-f show 10a. Stete 10b. County 10c_City, Town or Locetion 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at Kandal Director 1 ☐ Yes 2 Ø No timore 1.Stown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral APT/A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 W No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Specify: Completed by Specify. 3 ☐ Widowed 4 Ø Divorced 111 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Services 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be -edikiAH acoline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mercer 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) A RondAlls town, mo 21133 altimore, 20a, Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State ò nount Crematory 11-22-04 BALTIMORE MD 22. Name and Address of Fecility Vaugur C Greene Foneral Services 4 ☐ Donetion 5 ☐ Other (Specify) reen Mount Crematory 21. Signature of Funeral Service Licensee 8728 Liberty Rd Randalls Town, MO 21133 seene 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL MMEDIATE Examiner Due to (or as a consequence of): Examiner ATHEROSCLEROTIC HEART attending physician and for use as the burial-transit The law requires that the daath certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. DId tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown PULMONARY OBSTRUCTIVE þ cata has been sig , page 2 should b 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? Completed 24a. Was an autopsy performed? HYPER TENSION s after death.

al Director: After this certificata he tied in by the funeral director, page 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No INSULIN DEPENDENT DIABETES or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) complataly filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. edicai 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Owens MD.

Registrar

usan 31. Date filed (Month, Day, Year) JAN 2 1 2004

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W.

32. Registrer's Signature

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

OWERS MD

ORIGINAL

DZZ751

NORTHWEST HOSPITAL CENTER

Vanuary 16, 2004

PANDALISTONA PIARVIANA ZII

DHMH 16 Rev 6/95

			1 - For Amend Item 26	State of J	Maryland / Depi	artment of F	leaith and M <i>Death</i>		iene 19. No. 201	04 01182
	Physic	ian	Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) Day Year							3. Time of Death
- Vig	/Medi	Gal Harriet Hall Bond UNUNRY 12 2004						104 2:33 AM		
N. Sec.	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death EDENWALO 76W90W						4c. County of	Death TIMORE
	Funeral		***	5. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth	.1.	
	Funeral Director		511-18-3494	1 □ M 2 💢 F	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 14	, 1917	Birthplace (State or Foreign Country) Maryland
	pc ,		Usual Residence of Decedent						1	
	larylan show	<u>_</u>	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ect	MD Baltin	nore	Towson	10f. Zip Code		14/	On Citizen of 14th	
	with be or	Funeral Director	800 Southerly I	Road 1003		21 286		1	Og. Citizen of Wha	
	death	era	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.1		ispanic Origin? (Spanic Origin)	ecify Yes or No-	United 14. Race -	American Indian,
9	after o	Ē	1 Never Married 2 Marrie	Armed Force	⊠ No			Rican, etc.)		White, etc.
93	urel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1□Yes 2√√ No	Specify:		Specify:	White
21215-0036	"net	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	6b. Kind of Busin	
12	withii ene. than	m d	Elementary/Secondary (0-12)	College (1-4d	or 5+)	istered (Vetrans	Admin.
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or Items 23e or 28e-1 show avant, if w Medical Exer in set i was be instifted at	a	17. Father's Name (First, Middle, L.	·		iraceren i	18. Mother's Name	(First, Middle, M	faiden Surname)	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla to f Heath and Mental Hygiene. If itam 27 is marked other than "neturel", or items 23e or 28e-1 show or other traumatic event, if a Meulical Exertinational Legislical at	To B	Joshua Bond				Cathe:	rine R.	Brown	
ary	2 short and h		19a. Informant's Name/Relationshi				and Number or Rura			
	permit. Pages 1 and 2 Department of Health a Important: If itam 27 I any injury or other tra once.		Nancy Warmingto	on/Trust O				-	ore, Mar	yland 21286
Baltimore,	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 ☐ Burial 2 ☑ remation	B ☐Removal from Sta	le l	natory or other plac	e)		0c. Location - Cit	y or Town, State
,≣	t. Partmen		1 □ Burial 2 🕅 remation 3 · 4 □ Donation 5 □ Other (Special Control of the cont					/2004 _		, Maryland
Ba	permit. Departri		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Ir 1050 York Road Towson, Maryland 21204							
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
	Parameter .	ā I	Shock, or heart rature. List only one cause on each line. Immediate Cause (Final Onset and D						Interval Between Onset and Death	
4	Pnysician /Medical	disease or condition						20411		
Examiner O() 3 a consequence of).					NID	A	15425			
10	₽ ≃	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Dife to (or	as a configurance of):	,			-,	15 1
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	a E	,	- Due to (or	as a consequence of):					
687	ficate phys s the	edical		d.						
Вох	eath certifi attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor					23d. Date of	delivery
	death	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐Pregnant	at time of death 5]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
P.0	at the deby the by the stached	hys	9 □ Unknown "	9□ Unknown						
	res tha igned to be det	Ď	Part II. Other significant condition	s contributing to death	but not resulting in the ur	nderlying cause give	en in Part I.		\	te to the cause of death?
oro	requir been s should	ted						1 Tes	2 D No 3 D	Probably 4 Unknown
Vital Records,	e law has b	Completed						24a. Was an autopsy perform	prior	e autopsy findings available to completion of cause of
a	an: The tificate hator, page		05 100					1 ☐ Yes 2	No 1□	Yes 2□ No
₹	rec cer	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	itient 2 ER/Outpatien	t 3□ DOA Othe	26. Place of Death			2
o		!-	27. Manner of Death	28a. Date of Ir	jury 28b. Time of			28d. Describe hov	ice 6 Dother (: v injury occurred	э <i>рөспу)</i>
So set to the set of										
ĭŠ	i or Atta after de Diracto	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place of	Injury - At home, farm, streetc. (Specily)	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
	urs af urs af ural D									
	To the Hospital or Attu within 24 hours after de _To tha Funaral Diracto completely filled in by th	Medical	29a. Certifier Check only one) Certifying 2 Medicel Ex	Physicien: To the be ceminer: On the basis and manner	st of my knowledge, death of examination and/or invested	occurred at the time restigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manne se and place, and	r as stated. due to the cause(s)
	To the within 2 To tha comple	Mec				29c. License	number	29	d. Date signed (M	onth, Day, Year)
	- s - ō		I follow of	lane		D2	858	5	AN UAN	4 13, 2004
	19		30. Name and address of person w	no completed cause o	death (Item 23a) (Type,	Print)	1 A A A	20.11	4.77	
	\		JOHN SHY	turns,	n 11 518	ר מיזוי ר	וונסאיוו	0(1)	·11) /77	21090
	Sta	ite	31. Date filed (Month, Day, Year) JAN 2 1 20	104 Page	strar's Signature	E)				, -
	Registr	ar	JANGIL	No. of the second	3,000					

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment tificate			nd Me		ene g. No. 2	004	01183
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Edward Lee Brown							2. Date of Death Month January	Day	Yeer 004	3. Time of Death
}	Examir		4e. Fecility Neme (<i>If not institution, give</i> Johns Hopkins Bay				own, or ltim	Location of I	Death			nty of Deeth	
*	Funeral Director		213-34-2998	7. Age	(In yrs. last birthday) 68 Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Birth (Month, Dey, 12/8/193	Year) 35	9. Birthi Coul Mary	place (State or Foreign ntry) 1and
	aryland show dat	<u>.</u>	Usuel Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo							1	0d. Inside City Limits
	th the M. or 28a-f	Jirecto	MD N/A		Baltim	ore	Code			10	g. Citizen o	of What Cour	1 🗓Yes 2 🗆 No ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examble must be published an ODGE.	by Funeral Director	6827 Conley Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	t 12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	D	Vas Decede f Yes, specif	ent of His fy Cubar	1224 spanic Origin n, Mexican, F Specify:	n? (Spec Puerto R	cify Yes or No- lican, etc.)	14. R	S.A. Race · Americ Black, White, cify: Wh	
1215-00	within 72 hounds and "natural Elban "natural Elban" natural Elban "natural Elban Elb	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L		done di retired)	uring most o		g		f Business/In	dustry
Maryland 21215-0036	uid be filed v Mental Hygie irked other i	To Be Co	12 17. Father's Name (First, Middle, Last) John Brown		Mai	ntenar			Name	r (First, Middle, Ma K. Dill		turant name)	
e, Mary	1 and 2 sho Health and I tem 27 is mu		19a. Informant's Name/Relationship (Ty Barbara Ann Brown 20a. Method of Disposition	pe, Print)	6827	Conle	y S	treet		Route Number, o	Mary1		1224
Baltimore,	permit. Pages Department of Important: If it any injury or once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Sacred He	eart o	f J	esus 1		/04 Ba	ltimo	ore. M	aryland
	- No		23a. Part1. Enter the disease, or combishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	he death. Do not ente	5224 E	ast of dying	ern Av	enue	e Baltim	ore,	Mary1	Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner physician and physician and the print fluorial	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								he-1/5			
P.O. Box 68	ath certific ttending p or use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pred Other (spec						Date of delive Month	ory Day Year
	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions cor	tributing to death but	not resulting in the un	iderlying cau	ısə givəl	n in Part I.		23e. Did toba			e cause of death?
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Vita	s certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	t 2ER/Outpatien	3 🗆 🗆 🗅				Check on one		44	
Division of Vital	Attending Physician: The lawer death. rector: After this certificate has by the funeral director, page 2		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day			c. Injury Work	at es 2 No	28	e 5 Hesideno 3d. Describe how	injury occi	urred	"
Divis	in Site	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory,	office		28	3f. Location (Stre- City or Town,	et and Nun State)	mber or Rura	l Route Number,
	To the Hospital or within 24 hours after to the Funersi Dir completely filled in	edical (29a. Certifying Physical Certifying Physical Check only one)	sician: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or inved.	occurred at estigation, in	the time	e, date and p nion, death (occurred	d due to the cau	se(s) and r and place	manner as st e, and due to	ated. the cause(s)
	To the within a comp	Me	29b. Signal and title of certifier) van	0		License) 2 [,			ned (Month, 1	
	Ve		30. Name and address of person who co	()	3730	Falls	R	0	7	Bultin	ne d	Hol Z	1211
ĺ	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 2004	32 Registrar		alls s			,				,

DHMH 17 Rev 1/2001

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		1 - State RegistraAMEND ITEM #12	State of Marylar PER FH G827 1/27	nd / Depa 7/04 <i>J</i> ਜ਼ਿੰ <i>e</i> ।	artment of H rtificate of L	ealth a Death		Reg. No.	200	0 8
Physici /Medic		1. Decedent's Name (First, Middle, Las Henry		ooks			2. Date of D Month Januar	Day		
Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	Death	4c.	County of De	eath
	Н	Carroll Hospital		*	West	minst	- 11 T		Carro	
Funeral Director		5. Social Security Number 6. Security Number 218 - 44 - 7869	ex 7. Age (In yrs. ▼ M 2□F 58	Yrs.	Months Days	Hours	Min. (Month. D	ay, Year)	9.6	Birthplace (State or Foreign Country) Maryland
nd Mantal Hygiene. marked other then "naturel", or Items 23e or 28a-f ehow umatic event, the Medical Examinar must be motified at		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation					10d. Inside City Limits
i resulti and water hygene i returni and see or 28e-1 show them 21 see or 28e-1 show other treumatic event, the Madical Examinational be notified at	ctor	MD Baltim	nore	R	eistersto	wn				1 □ Yes 2√ No
or 28 De no	Director	10e. Street and Number 702 Earlton R	ond		10f. Zip Code	26		-	zen of What	Country?
Dust	Funeral	11, Marital Status	12. Was Decedent Ever in U	15 13	2113		in? (Specify Ves or N		S.A.	merican Indian,
zaminer	by Fun	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? ***Types 25 to 196 #Yes, Give Year or Dates: 1973	o/ -	If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Black, Wi	
ical E		15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occupa		-611	16b. Kir	nd of Busines	
Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done di DO NOT use retired)		of working			
4		17. Father's Name (First, Middle, Last)	4	Proje	ect Manage		- N /E' 41'-4"			Corporation
0 0	Be C	Henry Arthur C	rooks				's Name <i>(First, Middle</i> cgaret	, <i>маюва</i> Mur		
mati	2	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street a		or Rural Route Numb		1 2	. Zin Code)
or tre		Audrey M. Crooks	Wife				Reistersto			
r oth		20a. Method of Disposition 1 Surial 2 Cremation 3		Place of Dispo	sition (Name of matory or other place	1	Date			or Town, State
lury o		`4 □Donation 5 □Other (Specify	Re:	isterst	own Meth.	Cem				wn, Maryland
eny injury or other gages.		21. Signature of Funeral Service tricens	Elin		Name and Address LINE FUNER	,				
ician dical allo step provide the private step private step priva	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence to (or a))).	quence of):	telenocaro	einen	n4			Interval Batween Onset and Death
מוסחות הם תפופתופת וכו תאם שא	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			2	3d. Date of d Month	elivery Day Year
De deta	by Pr	Part II. Other significant conditions co	intributing to death but not res	ulting in the ur	nderlying cause giver	n in Part I.	23e. Did	obacco us	se contribute	to the cause of death?
suonia							_ 10	Yes 2□]No 3□F	Probably 4 Unknown
page 2	Completed						24a. Was auto perfo 1 Yes	psy prmed?	24b. Were a prior to death?	
rector	Be	25. Was case referred to medical examiner?	Hospital:		Othor		of Death Check only			
neral	lon; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury : Work?	4 U Nurs	28d. Describe			ecify)
d in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	ome, farm, stre		63 2 110		Street and wn, State)	Number or F	Rural Route Number,
completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death ition and/or inv	occurred at the time restigation, in my opin	e, date and nion, death	place, and due to the occurred at the time,	cause(s) a date and p	and manner a place, and du	as stated. se to the cause(s)
Сот	Me	29b. Signature and title of certifie	1/1		29c, License	number		29d. Date	signed (Mor	nth, Day, Year)
		1100	mo		03	3189	(Jan	com 2	0,2004
1+		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Typa, f	Print)	0	H- DEL	(2	(AHA)	ma. 000
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	1		**		14	1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Month 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day a nugr 4b. City, Town, or Location of Death give street end number) Facility Name (If not institution, CENTER 4 MediCAL DALL MURE more If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) if Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Min. Months Days Hours **₩** 2□ F 70 Yrs 041-32-7622 Usual Residence of Decedent NC 09 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 √Yes 2 □ No Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 3322 Haywood Ave 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Shell Gas Station Mechanic 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clara Floyd James Chavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21215 3322 Haywood Ave, Baltimore Md Rose Chavis-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1/22/04 Owings Mills, 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore Md 21215 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

pital or Attending Physician: The law requires that the death certificete be executed

this certificete

efter death.

24 hours e

within 2 To the To the

completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

by Physician/Medical Examiner

Be Completed

Medicai Certification: To

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

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Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylend Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "net---".

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

each line.	
Aspiration &	Prevmonitis
Due to (or as a consequence of):	
Nagsive IInt	515
Due to (or as a consequence of):	

30 migute

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco usa contribute to the cause of death? 2 3 Probably 4 Unknown 1 Tyes

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Was 2□No

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1 🗆 Yes	2 No

ase referred to medical		26. Place of Death (Check only one)								
er? s 200 No	Hospital:	2 ER/Outpatient	з□ роа	Other:	4 ☐ Nursing Home	5 Residence	6 □Othe	r (Specify)		

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

use of death (Item 23e) (Type, Print)

1 Ye 27. Manner of Death

3 Suicide

29a. Certifier

4 Homicide

30. Name and address of person

25. Was c

5 Pending investigation 1 Natural 2 Accident

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of

Due to (or as e consequence of):

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

0

32. Papistrar's S

29c. License number

29d. Date signed (Month, Dey, Yeer)

IDN GREENE Street

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 [For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:53 ам JOHN JARRELL January 9, 2004 CASHMERE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery 10401 Grosvenor Place North Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Hours XXM 2□ F 69 25, 1934 Pennsylvania Director June 201-24-7717 Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rai", or items 23a or 28a-f ahow Exemple: must be notified at XXXYes 2 □ No MD Montgomery Directo North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10401 Grosvenor Place 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 Types 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: white \$ 3 ☐Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) +4 Naval Officer Navy la marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Kar1 Cashmere Agnes Cashmere 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if of Health John D. Cashmere/Son 6509 Marjory Lane, Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 1/11/04 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Fureral and Cremation Center 1040 Rockville Pike Rockville, MD 20852 THE 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Rena1 Failure 4 years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2√XNo this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After t the Hospital or Attending 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide **EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier 29b. P54378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Cheryl Aglesward 6410 Rockledge Drive, Bethesda, MD 20817 32. Registra Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			1 - For State Registrar	State of Marylar	nd / Department of F Certificate of		ental Hygier	711111	01187
			Decedent's Name (First, Middle, Last	st)			2. Date of Death		3. Time of Death
	Physici		Cornelia (0/eman			Month D	Day Year	10:10AM
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		or Location of Death		4c. County of Dea	th ,/1
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	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Dey, Yee	9. Bir	thplace (State or Foreign ountry)
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	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Iniside City Limits
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	the 28a	rec	10e. Street and Number	1	10f. Zip Code	10,00	10g. (Citizen of What Co	ountry?
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	death ms 2	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent of I	Hispanic Origin? (Specan, Mexican, Puerto R	cify Yes or No-	14. Race - Ame	
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att	permit. Pag Department Important:: eny injury c		21. Signature of Funeral Service Licer	1500	22. Name and Addre	ess of Facility (WELLF	unerel	Home
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æ		Соп					performed?	? death?	
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7/	etely	Medical	(Check only 2 Medical Examone)	miner: On the basis of examin and manner stated.	ation and/or investigation, in my	opinion, death occurre	d at the time, date a	and place, and due	to the cause(s)
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	K.		30. Name and address of person who	0	om 23a) (Type, Print)	***************************************			
	8		soo W.	bothmore ;	54				
7	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's 30n	nature H Annual				

	_	1- State Registrar Amend Item #10	Fh,G827,01/23/04dhb f per fh,G827 1/21/0	Department of Health an 4Certificate of Death	Reg	j. No.
Physici /Medio		1. Decedent's Name (First, Middle, Las	CUNN	INGHAM	2. Date of Death Month JANUANY	Day Year 1453
Examir		4e. Fecility Name (If not institution, give No ATH WEST	HOSPITAL	4b. City, Town, or Location of D	TOWN	ALTIMORE
uneral irector		5 Social Security Number 249–32–5406 11 Usuel Residence of Decedent	7. Age (In yrs. last bi		Hrs. 8. Date of Birth (Month, Day,) 02 25	9. Birthplace (State or For Country) 9. SC
how		10a. State 10b. County	10c. City, Tow			10d. Inside City Lit
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ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		14. Race - American Indian,
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7 ls		19a. Informant's Name/Relationship (7		D. Mailing Address (Street and Number of		
Item 27 other tra		Thomiesena Cunn 20a. Method of Disposition	20b. Place of	of Disposition (Name of		Randallstown, Mc
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sician edical		23a. P. n.t. Enter the disease, or ching shock, or heart failure. List only disease or condition resulting in death)	plications that caused the death. Do one cause on each line.	not enter the mode of dying, such as call EUMONIA	rdiac or respiratory arres	t, Approximate Interval Between Onset and Deat
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ector: After by the funer	Medical Certification	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only Medical Exam	28e. Place of Injury - At home, f building, etc. (Specify) ysician: To the best of my knowledge	ie, death occurred at the time, date and p nd/or investigation, in my opinion, death 29c. License number	City or Town, place, and due to the cau accurred at the time, dat	State) se(s) and manner as stated. e and place, and due to the cause(s) d. Date signed (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend Item #8 per fh G827 1/21/04 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician EVA** COHEN Januarv 17 2004 3:40 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDÉRICK MEMORIAL HOSPITAL FREDERICK FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1/26/1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | Min. | 09 29 1911 | MD. | MD. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 K 92 217-34-5930 Director Usual Residence of Decedent the Maryland 10a. State MD CARROLL 10c. City, Town or Location WESTMINSTER 10d. Inside City Limits "natural", or Itams 23a or 28a-1 show ofical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 2207 HOPI COURT 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene. 21157 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes. Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced er than "nature". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other than 'r treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) SALESWOMAN RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EPSTEIN** LOUIS LENA ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) at of Heam.

At: If Itam 27 is MR. LARRY COHEN/GRANDSON 2207 HOPI COURT WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State ANSTE CONGREGATION 1/19/2004 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD. permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to one a consequence of): /Medical Obstructive Pulnomary Disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ¥ Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has burnector, page 2 s autopsy performe 2 No 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 9 2 ER/Outpatient 3 DOA After this funeral dir 28a. D te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 2 No 24 hours after death.

• Funerel Director: A

bletely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 0 DEA BL6786428 Wan MD Jan 14,2004 D 00 58726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Wette ML Warren mo

31. Date filed (Month, Day, Year)

Parkview Medical

32. Registrar's Signature

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30. Name and address of person the completed cause of dear (Item 23a) (Type Print)

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with the		10e. Street and Number 323 S. LEHIGH S	STREET		10f. Zip Code	21224		10g. Citizen of Wh	·
be filed within 72 hours after death with the Maryland lal Hygiene. Id other than "natural", or Items 23s or 28s-1 show event, it a Mudical Examiner must be recitied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ሺ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Λ Year or Dates:		3. Was Decedent of H If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rece Black, Specify:	- American Indian, White, etc. WHITE
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permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral)Service Lig			22. Name and Addre	ess of Facility	HARLES S	S. ZEILER	R & SON, INC. YLAND 21224
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To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date Monti	
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S Regis	tate trar	31. Date filed (Month, Day, Year)	2004 32. Registra	ar's Signature					
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Physician John William DiPietrantonio Jr. 15, 2004 10:05 am January /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner 1309 Old Eastern Avenue Baltimore Essex If Under 24 Hrs. 8. Date of Birth Month, Day, Yes 9/9/1943 Birthplace (State or Foreign Country)
 Maine If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months X 2□ F 212-40-0947 60 Yrs Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter deeth with the Merylend nent of Health end Mental Hygiene. snt: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10e, State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Baltimore Essex Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 1309 Old Eastern Avenue 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Merital Status N☐ Yes 2☐ No 1963— #Yes, Give Year or Dates: 1964 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 20 TVNo Specify Specify: White Be Completed by 3 Widowed 4 Divorced 1964 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Self-employed Mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 7 is marked traumatic ev John William DiPietrantonio Sr. Margaret Alice McLaughlin 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Lou DiPietrantonio 1309 Old Eastern Avenue Essex Maryland 21221 Wife Item 27 other t 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Depertment of Important: If it any injury or c 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/04 Gardens of Faith Raspeburg Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Md 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** CREATIC CANCER Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2000 tillYes 2 Min 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SEE esidence 6 Other (Specify) 1 Yes 2 1 No this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Menner of Deeth 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter d To the Funeral Direct completely filled in by 4 I Homicide To the Hospital 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier

Registrar

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31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

Lue, Baltimore, MO. 21227

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Examin	er	4a. Facility Name (If not institution, g					(1)		
		North Arundel 5. Social Security Number 6		je (In yrs. last birthday,	Glen Bt	urnie If Under 24 Hrs	8. Date of Bir	Anne Aru	IDGEL Birthplace (State or For Country)
Funeral Director		216-34-5253	X XM 2□ F	67 Yrs.	Months Days	Hours Min.	Jan. 1		Country) ennessee
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or 22	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
238 238	- a	1311 Donald Ave		- : II 0 I 0	W . B	21144	C	USA	merican Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If then 27 is marked other then "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Evantrial most be notified at once.	by Funeral Director	11. Marital Status 1 Never Married MM Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2\(\) If Yes, Give Year or Dates:	No 13.	Was Decedent of HIf Yes, specify Cubin 1 ☐ Yes ★★No		to Rican, etc.)	Black, Wi	
atura cal E	ed	15. Decedent's	<u> </u>		edent's Usual Occup			16b. Kind of Busines	ss/Industry
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giene giene	mo	8	College (1-401	Carpe	nter			Constru	ction
al Hy	Be Completed	17. Father's Name (First, Middle, La	st)				,	, Maiden Sumame)	
Via v Vient	ToE	Theodore Dale				Carrie	Bishop		
and l		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or R	ural Route Numb	er, City or Town, State	a, Zip Coda)
and alth		Anne P. Dale (W	ife)		Donald A				
of He		20a. Method of Disposition XX Burial 2 □ Cremation 3	□ Removal from State	20b. Place of Disp cemetery, cre	osition (Name of imatory or other pla	ce)	Date	20c. Location - City	or Town, State
Page ment ant: I		`4 □Donation 5 □Other (Spe			Episcopa	1/21	1/2004	Odenton, 1	MD
permit. Departr Import. eny inji		21. Signature of Funeral Service Lic	cense	2	2. Name and Addre	ess of Facility Funeral	Home 1	РΛ	
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	1	For State Registrar	State of Maryland		tificate of L			eg. No.	2004	01196
/sicia ledic	in	1. Decedent's Name (First, Middle, Last) Thomas Dent					2. Date of Deat Month	10ay	2004	3. Time of Death 6:00 p M
amine	er	4a. Facility Name (If not institution, give st Prince Georges Hosp	pital		4b. City, Town, or Cheves	-1y		I	Prince G	
eral ctor		5. Social Security Number 213-56-9967 Usual Residence of Decedent	M 2□F 7. Age (In yrs. II	ast birthday) Yrs.	Months Days	Hours Mir		Year) 950	9. Birthp Mary	lace (State or Foreign (ny) Land
Hed at		10a. State 10b. County MD Prince Ge		.Town or Lo	cation				1	0d. Inside City Limits 11 Yes 2 □ No
ST De LIG	=	10e. Street and Number 6704 W. Forest Rd A	pt.#103		10f. Zip Code 20785		1	•	en of What Coun SA	itry?
any injury or other traumatic event, the Mudical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hi I Yes, specify Cuba □ Yes 2 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		4 Race - Americ Black, White, Specify: White	etc.
De Modicel	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	16a. Deced (Give life. L Labor	lent's Usual Occupa kind of work done o OO NOT use retired	ation furing most of w)	orking		d of Business/Ind Private	dustry
atic event,	To Be C	17. Father's Name (First, Middle, Last) Percy Dent				Anna L	une <i>(First, Middl</i> e, <i>I</i> Duise Wal	lace		
TI LE		19a. Informant's Name/Relationship (Type Vida Dent/ Wife		6704	W. Fores	t Rd Ap	Rural Route Number t.#103, La			20785
ry or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place coln Cem.		Date 20/2004		ation - City or To ${f ntwood}$,	wn, State Maryland
once.		21. Signature of Fune al Service License	2				J.B. Jenk: Landove:	ins	Funeral	Home
cian ical iner	amlner	shook or heart failure. List only one limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.	Due to (or as a consequence of the death of the consequence of the con	CARDIL Jence of):		g, such as cardi		est,		Approximate Interval Between Onset and Death
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5	by P	Part II. Other significant conditions confi	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	İ	oaccous es 2□		ne cause of death?
director, page z snould	Completed	H					24a. Was a autops perform		24b. Were auto prior to con death? 1 Yes	psy findings available inpletion of cause of
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	ospital: 1 ☐ Inpatient 2 🔯	ER/Outpatier	t 3 DOA Oth	36	eath (Check only on Home 5 Reside		Other (Specifi	y)
E 0	Certification; T	27. Manner of Death 1 🖾 Natural 2 Accident 3 Suicide 2 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1 🗆	vat ⟨? Yes 2 □ No	28d. Describe ho			
100 1100		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify			and data and also	28f. Location (St City or Town	n, State)		
completely filled in by the	ledical	(Check only 2 Medical Examin	ician: To the best of my kno ler: On the basis of examina and manner stated.		vestigation, in my o	oinion, death occ	curred at the time, d	ate and	place, and due to	the cause(s)
000	W	29b. Signature and title of certifier	5 W		D D		76 PAL DRIL		signed (Month,	*
		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	l'hono.	TA: ADD	10	- In - 1 - C	am MD

		1- State of Maryland / Department	artment of Health and Me	ental Hygien	20114 111147
Physici		Decedent's Name (First, Middle, Last) Martin William	Duffy	2. Date of Death Month Da	ay Yeer 9:18 P M
/Medi Examir		4a. Facility Name (If not institution, give street and number) 809 S. Fountain Green Road	4b. City, Town, or Location of Death Bel Air	4	.County of Death Harford Co.
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-20-9688 1 XM 2 F 76 Yrs. Usual Residence of Decedent		Date of Birth (Month, Day, Year June 23,19	
the Marylan 28a-f show	Director	10a. State 10b. County 10c. City, Town or Lo Maryland Harford 10e. Street and Number	Bel Air	100.0	10d. Inside City Limits 1 ☐ Yes 2 ☑ No itizen of What Country?
be tited within 72 hours after death with the Maryland tal Hygiene. Ida Hygiene. Id other then "natural", or Itama 23a or 28a-1 show event, the Modical Examiner must be notified at	Funerai Di	809 S. Fountain Green Road 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Valves 2 No	21015 Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	τ	Inited States 14. Race - American Indian, Black, White, etc.
in 72 hours a	Completed by	3€ Widowed 4 Divorced If Yes, Give Year or Dates: WWII 15. Decedent's Education (Give (G	1 ☐ Yes 2 ☐ No Specify: dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. F Ba	Specify: White Who of Business/Industry Iltimore City
a a b y	Be	12 Years Fig. 17. Father's Name (First, Middle, Last)	refighter 18. Mother's Name (A	First, Middle, Maide	,
2 should and Men Is marke	2		ng Address (Street and Number or Rural F		or Town, State, Zip Code)
Daltillore, Mal yra permit. Pages 1 and 2 should Department of Health and Men Important: If tiem 27 1s marke any injury or other traumatic ance.	1	20a. Method of Disposition 1 ☐ Burial 24XCremation 3 ☐ Removal from State	natory or other place)	9 20c. L	ocation - City or Town, State
permit. P. Departme Important any injury 2005.		21. Signature of Funeral Service Licensee	Service Corp. 1/19/ Name and Address of Facility Duda-Ruck Funeral H	ome of Du	ndalk, Inc.
Pnysician /Medical	n d	23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition a	7922 Wise Ave. Dung er the mode of dying, such as cardiac or re	espiratory arrest,	yland 21222 Approximate Interval Between Onset and Death
be executed be executed be executed burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	Completed	Heffertonsa		24a. Was an autopsy performed? 1 ☐ Yes 2 A No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ng Ph fter th	Certification: To Be	25. Was case referred to medical examiner? 1	28c Injury at Work? M 1 Yes 2 No	5 Residence d. Describe how injur	ry occurred Id Number or Rural Route Number.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, and estigation, in my opinion, death occurred a	due to the cause(e)	and manner on stated
To the within To the	Me	29b. Signature and the et certifier the Mo	29c. License number 2 - (\$ / \$ -	Jo	te signed (Month, Day, Year)
511			T. PAUL PLACE 40.	9 BALT	IMORE, 41) 21202
Sta Registr		31. Date tiled (Month, Day, Year) JAN 2 1 2004 32. Segistrar's Signature	all		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #10c per fh G827 1/21/04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 6.36A 4 K,19 January 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Remedal 5 Teach

If Under 1 Year If Under 24 Hrs.

Anoths Days Hours Min. JAN 5, 1949 Baltivan west Centry North Hasp. Tal 5. Social Security Number 6 Sex Birthplace (State or Foreign MD.* 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 216-52-6988 Director Usual Residence of Decedent 10a. State BALTIMORE 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f ehow traumatic event, the Mactical Exempter relation of items. Reisterstown MD 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 USA 43 BONOAK COURT Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. WHITE 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **STENOGRAPHY** SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finance and Mental H VOLKIN PEARL GOODMAN DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any injury or other trac 43 BONOAK COURT REISTERSTOWN, MD. 21136 MR. ANGEL DIAZ/HUSBAND 20b. Place of Disposition (Name of HILLENTOP) CORP 1/19/2004 TOWSON, MD. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a consequence of) **Physician** /Medical Examiner Due to (g) as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 25 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 0 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Medical Certification; 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 17 Lewy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Durthwest Hospitall Emery 31. Date filed (Month, Day, Year) 2 1 20042. Registra Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:00 PM TARRYJ DIETER 1 2, 2004 4c. County of Death JANUARY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore B. Da 1624 RESCENT HVE BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 6. Sex Funeral Davs Hours 17 M 2□ F Months 213-09-3091 85 FEB. 9, Director MD. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after daath with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any highly or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Funeral Director BALTIMORE BERKSHIRE MD. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21224 U.S.A. 7624 CRESCENT AVE. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 🕅 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) POWER & COMBUSTION CO. STEAMFITTER 9TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B ELIZABETH NICHOLS WILLIAM GEORGE DIETER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 62 KING HENRY CIRCLE, BALTIMORE, MARYLAND 21237 ELLEN STANSBURY/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 1/16/04 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC., BALTIMORE, MARYLAND 21224 6224 EASTERN AVE., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical cardio myopathu Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probabiy 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) nours aftar daath.

neral Director: After this confilled in by the funeral dire 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aftar d To the Funeral Direct completaly filled in by 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) ND 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRYVIEW CIRCLE, Baltimore, MD 21224 BRUC STEPHANIE 5505 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1200

			For State Registrar	State of Ma	aryland /	Departmo			nd Mei	-	giene Reg. No.	200	40	1200
			Decedent's Name (First, Middle, L.	ast)					2.	Date of De	ath			ne of Death
	Physicia		Goldie	E. Ellis					J	an.	15,2		6	:45A M
)	/Medic Examin		4a. Fecility Name (If not institution, g			4b. C	ity, Town, or	Location of (_			County of De		. 1011
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	Funeral			Sex 7. Age	e (In yrs. last		der 1 Year	If Under 24	Hrs o	Date of Birt (Month, Da	h v. Year)	9. Bi	rthplace (Si	tate or Foreign
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	shov	7	MD 100. County		1	imore								Yes 2 □ No
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	eath	Funerai	11. Marital Status	12. Was Decedent		13. Was De			n? (Specif	v Yes or No		I4. Race - Am	encen India	an,
	ter d	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes,	pecify Cuba	ispanic Origin n, Mexican, f	Puerto Ric	an, etc.)		Black, Wh		
036	urs a	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2√☐ N If Yes, Give Year or Dates:		1 ☐ Ye	s 2 XNo	Specify:				Specify: $\mathrm{B}1$	ack	
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	item 27 other tr		Goldie Oden 20a. Method of Disposition	(niece)	20b. Place	of Disposition (. GI			cation - City o	r Town, Sta	te
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altimore,	permit. Pages Department of Important: If it any injury or o		* 4 □Donation 5 □ Other (Special Signature of Funeral Service Lice	1777	Ceda		and Addres		0-20	O4	DIO	OKIJII	MID	
Ba	Department of the post of the		E.N.WALKER	JR		/Este	p Bro Euta	os. Fi	uner Bal	al Se to MI	gry <u>i</u>	$\frac{\text{Se}_7^{\text{P}}}{217}$		
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П	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):	V	0					- 4	9
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Вох	leath certifica attending phate of for use as the	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			c pregnancy				2	3d. Date of d	elivery Day	Year
	ne dea the at hed fo	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	n 5 □ Other	(specify)					WORL	Day	
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Division	er des	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of inj	ury - At home c. (Specify)	, farm, street, fac	tory, office		28f	Location (Street and	d Number or I	Ru <i>ral R</i> oute	Number,
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		-	For State Registrar		State of M		l / Depa		t of H	ealth a		•		e 201	04	01201
	Physicia /Medic	n	1. Decedent's Name (First		/ . /	Ebk	pert					2. Date of D Month Java	D		(eer 200(f	3. Time of Death 3:00 A ^M
	Examin	er	4a. Fecility Name (If not i	1 Car	inty Ge	neval	Husp.			Coll	im				200	
	Funeral Director		5. Social Security Number 233-16-471.	5	Sex 7. A 1 □ M 2 X F	Age (In yrs. Ia 93	st birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of B (Month, D Aug 10	$\frac{1}{2}$	910	West	lace (State or Foreign try) Uirginia
	laryland show	10	MD	County			Town or Lo	cation							1	0d. Inside City Limits 1 ☐ Yes 2√ No
	with the h a or 28a-1 be noulfi	Director	10e. Street and Number	loward			diibia	10f. Zip						Citizen of Wh	nat Coun	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinat must be notified at	by Funeral	10850 Greet 11. Marital Status 1 Never Married 3 Xilliance 4 1	2 Married	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	nt Ever in U.S s? XNo				spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	USA 10-	14. Race	- Americ White,	etc.
21215-0036	vithin 72 hounde. ne. than "nature" e Medical E	Completed			Education rade completed) College (1-40	or 5+)	(Give lite.	dent's Usua kind of wor DO NOT us Teach	rk done d se retired,	luring most	t of worki	ng		Kind of Busi		dustry
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Maryland	d 2 should the and Ment of the market traumatic	<u>P</u>	19a. Informant's Name/F Sarah Ebbe:	Relationship				•	(Street a	and Numbe	er or Rura	I Route Num	ber, City			Code) ID 21044
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I eny injury or other tru once.		20a. Method of Disposition	on emation 3	Removal from Stat	te cei	ton Ma	nsition (Nam matory or o	ne of ther place	e)	C	9-04	20c.	Location - C	ity or To	
Balti	permit. Pac Departmen Important: eny injury once.		21. Signature of Funeral	~	11 doo	dll	V		Boyl 322	e Fun Aim A	eral	Home e West	on,	WV 2	6452	25%
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Division of Vital Records,	sician: The law require certificate has been si lirector, page 2 should b	Complete											opsy formed?	pri de		psy findings available appletion of cause of 2 \(\text{No} \)
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Divi	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur		4 Homicide	Certifying	28e. Place of building,	etc. (Specify))			ne, date an		City or T	own, Sta	ate)		I Route Number,
	fo the Hos within 24 ho fo the Fun completely	Medical	(Check only 2 2 29b. Signature and title	Medical Ex	aminer: On the basis and manner	s of examinati	on and/or in	vestigation	, in my op	oinion, dea	ith occurr	ed at the time	a, date a	and place, an	Month.	the cause(s)
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unknown 04-019 Jackie Marvin Frost 04-00360

> Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than *natural*, or Items 23s or 28s-1 show any injury or other traumatic event, Ita Medical Exactifiest must be notified at ODEs.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

•	For State Registrar	11000			nd / Depa	artment of H rtificate of L	ealth and N	Mental Hyg	_	04 01202
	1. Decedent's Name	e (First, Middle,	Last)					2. Date of Dea _Month		3. Time of Death
ı		Marvin						Januar	4	
	4a. Facility Name (/				c	4b. City, Town, or Elkric			4c. County of t	
	Northboun						If Under 24 Hrs.	B Date of Birth		
	5. Social Security N		3. Sex 1⊠M 2□F	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey 9/20/19	Year)	Birthplece (State or Foreign Country) OHIO
-	299-32-44 Usual Residence of			64				9/20/15	7.77	OUIO
Ì	10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	MD	Carrol:	1	Fir	nksburg	7				1 ☐ Yes 2 XNo
1	10e. Street and Nur		L		INDDULE	10f. Zip Code		1	0g. Citizen of Wha	t Country?
	2518 Cor	nstalk l	Drive			21048			USA	
	11. Marital Status			edent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - A	American Indian, White, etc.
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	3 Widowed	4 Divorced	Year or I	Dates:						White
((Spec	15. Decedent's cify only highest	s Education grade completed,)	(Give	dent's Usual Occupa kind of work done of	uring most of work	king	16b. Kind of Busin	ess/Industry
-	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)		DO NOT use retired			Transalria a	
	17. Father's Name	(Firet Middle I	2 2		Petro.	Leum Trans		e (First Middle.	Trucking Maiden Sumame)	
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1	Geraldin			e		Cornstall				
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1	1 Burial 2	Cremation	3 □Removal from ecify)	State	-	matory or other plac Cremation	1	7/200/	Hampstead	MD
	21. Signature of Fi			Ca		2. Name and Addres				
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+	23a Part1 Enter I	the disease, or	complications that	caused the dea		line Fune to the the mode of dying				Approximate
	shock, or hea Immediate Cause	rt failure. List o	nly one cause on	each line.						Interval Between Onset and Death
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2	in the past 12 1 \square Yes 2			nant at time of		Other (specify)			Month	Day Year
	9 🗆 Unknowr									
2	Part II. Other signi	ficant condition	ns contributing to	death but not re	sulting in the i	underlying cause give	n in Part I.	_	_	ite to the cause of death?
								1 🗆 Y	es 2 No 3	Probably 4 Unknown
Paraldinos								24a. Was a autop	an 24b. Wei	re autopsy findings available r to completion of cause of
5								perfor	med? dea	
,	25. Was case refe	rred to medical					26. Place of Dea	th (Check only or	ne)	
2	1 XYes 2] No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	ent 3 DOA Othe	4 Nursing H	ome 5 Resid	ence 6XOther ((Specify) at scene
Ě	27. Manner of Dea 1 ☐ Natural	th 5 Pending	/3.40	of Injury onth, Day Yeer)	28b. Time of Injury	Worl	?		ow injury occurred	DRIVERUE
3	2 Accident	investig	ation	3/04	246		′es 2 □No	MVLT	C-VEHIL	
	3 Suicide 4 Homicide	6 Could n determi	ned 28e. Plac	of Injury - At I ding, etc. (Spec	nome, farm, st	treet, factory, office		28f. Location (S City or Tow	treet and Number on, State) NOD	THE UNIND I -95
Medical cel illication;				Fr7	ERSTA	TR HIGH	WAY	ATMILE	MARKERY	6, ELKRIPHE, MD
S	29a. Certifier (Check only	1 Certifying	xeminer: On the	basis of examin	nowledge, dea	th occurred at the tin	e, date and place sinion, death occu	, and due to the o	ause(s) and manne date and place, and	er as stated. I due to the cause(s)
ממ	one)		and ma	nner stated.					29d. Date signed (A	
4	29b. Signature and	Tellines to entitle	1 //			29c. Licens	THURST		January 1	
		1/	1.1	rus						
	30. Name and add	ess of person	who completed ca	use of death (Ite	m 23a) (Type	, Print) 111 p	enn Stre	et. Balt	imore. Ma	aryland 21201

20+1

State Registrar 30. Name and address of person who completed cause of death (Item 2007, 177).

MARY G. RIPPLE M.

31. Date filed (Month, Day, Year).

32. Registrar's ingnature.

				/pe or Prin State of Ma					•		_	0.1	000
		1 - For State Registrar			, (/	Certificat				g. No.	2004	UI	203
Phys /Me	ician	1. Decedent's Name (First, Robert	, Middle, Last)	Scott		Fie	esel		2. Date of Death Month Sanuary	Day	Year 2004	3. Time	of Death
	nine	4a. Fecility Name (If not in:	. /	reet and number)	Han.	4b. City,	Town, or Locatio	/	1:41	4c.	County of Deat	h	
Funer Direct		1he John 5. Social Security Number 213-13-979	6. Sex	7. Age	(In yrs. last b	irthday) If Under Months		der 24 Hrs. s Min.	8. Date of Birth (Month, Day,	Year) 197	9. Birt Co 2 Ma	hplece (State	or Foreign
anyland ehow			County	3	10c. City, To	vn or Location	T		41			10d. Inside	City Limits
r 28a-f	rout	MD. 10e. Street and Number	Harfor	α		10f. Zip	Jarret Code	TSV11		0g. Citiz	zen of What Co	untry?	
ath with	2	3938 1	Rush R				210				ted S		
be filed within 72 hours after death with the Maryland tal Hygiene. al Hygiene of other than "natural", or Itams 23a or 28a-f ahow event, the Marical Exemitien into the retition at	hy Eurorai Director		☐ Married	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ever in U.S.	13. Was Dece	tent of Hispanic (cify Cuban, Mexic No Speci	can, Puerto R	city Yes or No- lican, etc.)		I4. Race - Ame Black, White Specify:		
hin 72 hou	patalomo	15. Do (Specify only Elementary/Secondary)	ecedent's Educa highest grade			a. Decedent's Usua (Give kind of wo life. DO NOT u	rk done during m	nost of working	g	16b. Kir	nd of Business/	Industry	
led with ygiene her tha	2	12		0	'	Plu	mber	ula ada Alama	(First Adiabatic A		Plumbi	ing	
d be fill to the control of the cont	9		Franc	ie Thi	esel	Jr.		bra	(First, Middle, M Anne			chell	
an y ic should and Men s marke	۴	19a. Informant's Name/Re				b. Mailing Address							
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than only injury or other traumatic event, Italy.		Joseph F. 20a. Method of Disposition 1 Burial 2 Crem	1			938 Rus of Disposition (Nar ery, crematory or c			rretts		lle, I		1084
t. Pages trent of I		'4 □Donation 5 □ 0	ther (Specify)	-01	Jarre	ttsvill							
permit. Departr Imports eny inje	Suc	21. Signature of Funeray S	sarrica Espaison	Kurt	ملازر		d Address of Fac Kurtz_	& Son	rrett	SVI.	lle, N	laryla	and
Physicia		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition	ease, or complic re. List only one	ations that caused cause on each lin		not enter the mod	e of dying, such	as cardiac or	respiratory arre	est,	TIOMO	Approxima Interval Boonset and	ate etween
/Medic Examin	al	resulting in death)	<u> </u>	Due to (or as		, , , , ,	11-52-24		. 10			5 da	45
ted hait	i me	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	te d	Due to (or as		not):	a ha	teres	1.0			5 %	V
be executed ician and burial-transit	10	resulting in death) Last	C.	Due to (br as			(ws 54		····· Q			- 00	43
tificate g phys	opo		d.										
I necolus, F.C. box oo rou, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be deatched for use as the burial-transit	Ohwaleles Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 □ Yes 2 □ No 9 □ Unknown	iami	c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal deat	h 3 ⊟Ectopic pi 5 □ Other (sp				2	3d. Date of del Month	ivery Day	Year
uires that the signed by lid be detacted.	40,74	Part II. Other significant of	conditions cont	ributing to death bu	(0)	in the underlying o	ause given in Pai	urt I.	23e. Did tob		se contribute to INo 3 □ Pr	the cause of	
2 a a									24a. Was ar autopsy perform 1 Yes 2	/ led?	death?	itopsy finding completion of	
ystcian: The ystcian: The is certificate had director, page	0	25. Was case referred to		ospital:				ace of Death	(Check only one				
Physi rthis c	F	-	110	28a. Date of Injur	y 28b.		Other: 4 4 4 4 4 4 4 4 4 4		e 5 🗌 Reside 8d. Describe ho			cify)	
MISTOTI OI VILCA Attending Physician: of death. ector: Atler this certific. by the funeral director,	1	1 Natural 5 🗆 2 🗀 Accident	Pending investigation	(Month, Da)	Year)	Injury M	Work? 1 ☐ Yes 2	□No					
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of the thing the funeral of the thing the funeral of the funeral o		3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injubulding, etc		arm, street, factor	, office	28	Bf. Location (Str City or Town	eet and , State)	d Number or Ru	iral Route Nu	mber,
Hospi 24 hou Funer etely fill			ertifying Physi ledicel Examin	cian: To the best of er: On the basis of and manner sta	examination a	ge, death occurred nd/or investigation	at the time, date, in my opinion, d	and place, ar death occurred	nd due to the ca d at the time, da	use(s) ite and	and manner as place, and due	stated. to the cause)(s)
To the within To the		29b. Signature and title of	certifier	1734	100	290	: License numbe	er	29	d. Date	e signed (Monti	h, Day, Year)	
		Josh da	wi	M.D.	Ph.D.	Fellow	0600	46	50	we	ery 5	2004	
		30. Name and address of	person who con	npleted cause of d	eath (Item 23a) (Type, Print)	Builde	MolN	orth Brow	0	R. 4.1	no Min	37-37 Oct
	State			004	Yo Co	he hear	8,	31	Jillian val		11		-

DHMH 17 Rev 1/2001

ORIGINAL

		1 State		Maryland / Dep			Mental Hyg	iene 20	Inl. ni	20
		1. Decedent's Name (First, Middle, I		328 2/09/04 UHP	rtificate of	Death	2. Date of Deat	eg. No.	UW UI	40
Physic			Fedczak				Month	Day	Year	
/Med		4a. Facility Name (If not institution, o		ar)	4h City Town or	Location of Death	January	17, 20	004 14:3	<u>37 </u>
Exami	ner	Johns Hopkins Bay		,				4G. County	or Death	
Funeral	Т			Age (In yrs. last birthday)	If Under 1 Year	imore If Under 24 Hrs.	8. Date of Birth	<u> </u>	9. Birthplace (State of	or Fornia
Director		233-78-8734	1 □ M 2 🔀 F	56 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 30	Year)	West Virgi	
D		Usual Residence of Decedent					_ bcpc.50	91777	West VIIg	шта
larylan show		10a. State 10b. County		10c. City, Town or Li	ocation				10d. Inside C	City Limits
e Ma	cto	MD Prince	George	Laurel					t y Yes	2 □ No
th th or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Country?	
23a		15609 Dorset Roa	d #202		20707			USA		
within 72 hours after death with the Maryland jiene. rithen "natural", or items 23a or 28e-1 show the Medical Evana withing the notified at	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		- American Indian, k, White, etc.	
S afte		1 Never Married 2 Married	I 1 ☐ Yes 2 ∑ If Yes, Give	Q No	1 ☐ Yes 2X No	Specify:	rtioan, bio.		White	
hours	d by	3 ☐ Widowed 4X Divorced	Year or Dates	5:		ороолу.		<i>Specify</i> :	willte	
in all y faired within 72 hours at the act when all Hygiene. 27 Is marked other than "natural", or treumatic svent, the Medical Event.	Completed	15. Decedent's (Specify only highest g	Education grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of work	ing	16b. Kind of Bus	siness/Industry	
within ene. than	E G	Elementary/Secondary (0-12)	Coltege (1-40	r 5+)					,	
be filed with stal Hygiene. Id other than		17. Father's Name (First, Middle, Las		FIIgn	t Attenda	18. Mother's Nam	o (Fire) Middle 1	Airli		
Mental arked o) Be		,						3)	
should nd Men marke	7	Michael Maximil 19a. Informant's Name/Relationship		10h M-18		Alice Ru				
d 2 sho d 2 sho th and 7 Is mu treums		Marilyn Fedczak			ng Address (Street a					
		20a. Method of Disposition	/ bistel	20b. Place of Dispo	U DOTSET	Road #10			land 20707	<u>/</u>
Definition of the partment of Heal mportent: If item iny injury or other partment.		1 ☐ Burial 2 ☐ Cremation 3		20b. Place of Dispo cemetery, crei			14	euc. Location - C	City or Town, State	
permit. Pag Department Importent: I Iny injury o		* 4 □ Donation 5 □ Other (Spec	**	Balt/Wash					Maryland	
permit. Department importer siny injurence.		21. Signature 1 Juneral Service Lic		フィファン	. Name and Addres		leck Fun	eral Ho	me, Inc.	
		23a. Part1. Enter the disease, or co	X-		601 Sandy	Spring	Road, La	urel, Ma	aryland 20)707
Physician / Medical Examiner bulkstician and street physician and street	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequence of): is a consequence of): is a consequence of):	and smother	e wa kot	tqi	2 10/16 4 61 8 11 2	5	
death certi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2₺ No 9 □ Unknown Part II. Other significant conditions	4☐Pregnant : 9☐ Unknown	2 ☐ Fetal déath 3 ☐ at time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date Month	h Day Y	Yea r
law requires that the as been signed by the 2 should be detache	ted by	, atti. Otto, signiloan conditions	contributing to death	out not resulting in the dr		n in Part I.	23e. Did toba		oute to the cause of de	
The ate h page	e Completed	25. Was case referred to medical	1				24a. Was an autopsy perform 1 ☐ Yes 2	ed? dea	ere autopsy findings a or to completion of ca ath? Yes 2 \(\) No	available ause of
Attending Physician: ir death. ector: After this certification by the funeral director.	o Be	examiner? 1 X Yes 2 No	Hospital:	iont 2000	Other	26. Place of Death				
Phys rthis ral di	F	27. Manner of Death	1X Inpat 28a. Date of Inj		JU DOA	4 Inursing Hor	ne 5 ☐ Residen 28d. Describe how			
ding Ph h. After th funeral	ertification:	1 Natural 5 Pending	(Month, D	ay Year) Injury	A 28c. Injury Work	es 2 🕱 No		relived is	1	0
or Attencafter death Director:	fica	3 Suicide 6 Could not I	DB 200 Place of to	ijury - At home, farm, stre			- J			
after Dire	erti	4 Homicide	building, e	etc. (Specify) Athor			City or Town,	State)	or Rural Route Numb	
spite ours nerel	O	29a. Certifier 1 ☐ Certifying P	hysician: To the hes				509 Dorse	F Rel #20	2 Lourely 1	MU
24 h 24 h Fur etely	edical	(Check only one) 2X Medical Exa	miner: On the basis of and manner s	t of my knowledge, death of examination and/or invitated.	estigation, in my opi	nion, death occurre	and due to the cau and at the time, date	ise(s) and mann e and place, and	er as stated. d due to the cause(s)	
To the Hospitel or Atten within 24 hours after deat To the Eunerel Director: completely filled in by the	Me	29b. Signature and title of certifier	Sing managers		29c. License				Month, Day, Year)	
F 3 F 8		7/1	2 1	e -		.C.M.E.			* * * * * * * * * * * * * * * * * * * *	
X		20 Name and	0 7/1					Jaruary	18, 2004	
0		30. Name and address of person who	H AL	death (Item 23a) (Type, F	enn Stree	t, Baltin	ore. Mar	vland 2	21201	
* C1		31. Date filed (Month, Day, Year)	_	ra Signature	added Were	,		- <u> </u>	• 	
Sta Registr	1.0		0 1 2004	E. M	Land 1					

			For State	State of Mary	/land /		artment o			ind M		giene Reg. No.	211	04	012	15
			Registrar 1. Decedent's Name (First, Middle, Las.	()							2. Date of De	ath			3. Time of Dea	h
	Physici		Jerry Lee Fer	tia							Month Janua	rv	, 16,2	Year 004	2:30P	M
>	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, To	wn, or	Location of	f Death			County o			
	Exami	eı	Anne Arundel M	edical Ce	nter		Ann	abo	olis			A	nne	Arui	ndel	
	Funeral		5. Social Security Number 6. Se	7. Age (Ir	yrs. last b	irthday)	If Under 1 \			24 Hrs. Min.	8. Date of Bird (Month, De	th Year		9. Birthpla	ace (State or For	eign
	Director		213-75-1934	X M 2□F 4	1	Yrs.	Months	ays	Hours	IVIII.	04/01	/19	62		" MD	
	p		Usuel Residence of Decedent	10	c. City, Toy									10	d. Inside City Lir	nite
	rylar show	_	10a. State 10b. County	10										"	1 ☐ Yes 2 🛣	
	Sa-f s	ct C	MD Anne Ar	undel	Pasa	den		_								
	다. 이 24	Director	10e. Street and Number				10f. Zip Co		_				zen of Wi		ry r	
	23a		219 Kenwood Ro					12		: 0.70	7.14		. S . A		a ladice	
	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exeminer must be multibled at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13.	Was Deceden If Yes, specify	Cuba	ispanic Orig in, Mexican,	, Puerto l	cify Yes or No Rican, etc.))-		, White, e		
36	ori	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:			1 ☐ Yes 2 📜	No	Specify:				Specify:	Wh	ite	
8	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show odical Examilier must bu notified at		15. Decedent's Ed		16	a. Dece	dent's Usual C	Occupa	ation			16b. K	nd of Bus			
5	n 72 ho "natur edical	Completed	(Specify only highest gra-	de completed)		(Give	kind of work of DO NOT use	done d	during most	of worki	ng					
12	within ene. then	щc	Elementary/Secondary (0-12)	College (1-4or 5+)	R	ece	iving	С	lerk			Bur	ling	ton	Coat	Fac
2	iled Hygi ther nt,	ပိ	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,	, Maiden	Sumame)		
an	ed la b	To B	Dale Andrew Fe	rtia					Hel	en T	/irgin	ia	Neff	•		
Maryland 21215-0036	d 2 should th and Men 7 Is marke traumatic	Ĕ	19a. Informant's Name/Relationship (7		19	b. Maili	ng Address (S	Street a			l Route Numb				Code)	
Z	7 2 2 2 2 2 2 2		Helen Strevig/N	other	2	19	Kenwo	od	Rd.	, Pas	sadena	, MD	211	.22		
ė,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place	of Dispe	osition (Name matory or othe	of			ate		cation - C		vn, State	
ē	9°= 5		1 ☐ Burial 2 🛣 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify							01/3	20/04	Ra 1	t i mc	re.	MΤ	
Baltimore,			21. Signature of Funeral Service Licen		Dayv	2	2. Name and	Addres	ss of Facility	y G .	J.Gonc	o F	unar	a1	Home	
Ba	permit. Departr Importa any inji		1 2 1 2								, Pasad					
			23a. Part1. Enter the disease, or comp	olications that caused the	e deeth. Do								,		Approximate	- 11
			shock, or heer failure. List only	one cause on each line.		10	L.	٨	-11	1 -					Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	a. Venir	51au	ILLI	- 91	0/\	1110	wn '	n				2000 CD	VV
1	Examiner			Due to (or as a c	onsequence	9 OI):	100	ه ۱	12+	500	ion				frank	
У		-	Sequentially list conditions,	b. Due to (or as a c	onsequence	of):	1 10	14	7	0 0 1	Rom				V-,	
	ted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	91100	Ain	C A	11,40		Sim	nd	ROM	ح		1	11.	
	and and	xar	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence	e of):	VUL		— () _ F	CV V						
8760,	cate be executed obysician and the burial-transit	alE														
387	phys the	dical		d												
9 X	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy								23d. Date	of delive	y	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 € 4 Pregnant at tim			□Ectopic preg □ Other (spec		'				Mon	th	Day Year	
	the de	ysic	1 Yes 2 No	9□ Unknown				,,								
P.0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	P.	Part II. Other significant conditions of	ontributing to death but r	not resulting	in the	anderlying cau	se giv	en in Part I.		23e. Did t	tobacco i	use contri	bute to th	a cause of death	?
ds,	ires tha signed I	d by									1 🗆	Yes 2	DXXIIo :	3 🗌 Proba	ibiy 4 ∐Unkn	own
5	w requir been si should	Completed									24a. Was	an	24h W	lere autor	sy findings avail	able
ec	e 2 s	idu									auto		pr de	ior to con eath?	pletion of cause	of
쁰		S									1 Yes	2 No		Yes	2□ No	
/IE	hysiciar: The law his certificate has I I directo , page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			.	Oth	or		(Check only o					
of Vital Records,	Physician: rthis certificant	2	1 Yes 2 No	1 Inpatient	2 ER/0	Outpatie . Time (. Injun	4 □ Nu		me 5 ☐ Resi 28d. Describe)	
_	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Y	eer)	Injury	M 200	Wor	k?" Yes 2⊡!		Edd. Describe	now inju	y 0000110			
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b		At home	form o			163 2		28f Location /	Street ar	nd Numbe	r or Bura	Route Number,	
Ξ	or At after d Direct in by	E	4 Homicide determined	building, etc. (Specify)	iaiii, S	reel, lactory, (OHICE			City or To	wn, State	9)	0, 7,0,0	710010 710777001	
	urs a		A Continue Di	ungigings To the heat of	mu knowlod	no dos	th accurred at	the tin	no date an	d place	and due to the	cause/s	and man	ner as st	hete	
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral to	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exer	ysician: To the best of r niner: On the basis of ex and manner state	camination a	ge, dea and/or i	nvestigation, in	n my o	pinion, dea	ith occurr	ed at the time,	date an	d place, a	nd due to	the cause(s)	
	the the mplet	Med	29b. Signature and title of certifier	and mainter states	·		29c. l	Licens	e number			29d. Da	te signed	(Month, L	Day, Year)	
	Vit To	-	250. Security and title of contine	1 to A		10	7 6	10	000	1 1	1-1	1_	- 1	7 -	-04	
			INNHW	1.000	uv	VVV	17 1	71	100	10	06	-,-			VI	7
	6		30. Name and address of person who	completed cause of deal	th (Item 23a	(Type	Print)	(C+2	110	2	L	in.	ERVI	ILEM	リ
			21 Date filed (Month Day Year)	32. Registrar's	Signatura	· U·	10/	2	- , , (حساس			-11-		7-100	>
	Si	ate	31. Date filed (Month, Day, Year)	101 State	igriature و ممياوستير	Ry	An	2. 10							クロリ	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Jan 14 2004 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of 7. Age (In yrs. Jast birthday) If Under 1 Year If Under 24 Hrs.

Yrs. Months Days Hours Min. Sinai Foster Hospital 11 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number "Sex **Funeral** 1₫M 2□F 0.12.591 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-1 show other treumstic event, it a Medical Examinating must be notified at 500 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 17/4es 2 1 No If Yes, Give Year or Dates: 14. Race -Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 0 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 53 Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. KNOWN Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Foster ney 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Holliday/Daughter 4110 Patient Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) laney Valley / monum 2. Name and oddress of Facility Cough, C. G-reene -une 21. Signature of Funeral Service Licensee Liberty Kd Kundallstolen, MD 2113 cene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he are failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rosepsis /Medical Due to (or as a consumence of): Examiner Acidosis 1etabolic Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? dementia 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Madical letely (and manner stated To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) from , per

5:50 PM

1 Yes 2 No

Services

Approximate Interval Between Onset and Death

2 No

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

Saren 31. Date filed (Month, Day, Year)

JAN 2

1 2004

			1 - For State Registrar	State of Marylar	nd / Depa	artment of I	Health and	Mental Hy	_	4 01207
			1. Decedent's Name (First, Middle, La	st)	1			2. Date of De Month		3. Time of Death
	Physicia /Medic		Slizabeth		rayo)		Jan	Day Yea	2:30 P M
<u>.</u>	Examin	_	4a. Fecility Name (If not institution, giv. 8323 Philadelphi	a Road		21237	or Location of De		4c. County of De Baltimor	e
77.	Funeral Director		5. Social Security Number 6. S 1 Usuef Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			th ly, Year) 9. B	Birthplece (State or Foreign Country) IARYLAND
	Maryland f ehow	tor	10a. State 10b. County MD Baltimo		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3e or 28e 1 be notifi	I Direc	10e. Street and Number 8323 Philadelphi	a Road		10f. Zip Code 2123	7		10g. Citizen of What USA	
36	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28e-f show event, the Medical Examination must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of his Yes, specify Cub		(Specify Yes or No arto Rican, etc.)	Black, W	merican Indian, hite, etc. Thite
ş	Phou Plura	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	ss/Industry
9500-91212	d within 72 piene. r than "na	Completed	(Specify only highest grades) Efementary/Secondary (0-12)	Colfege (1-4or 5+)		kind of work done DO NOT use retire grapher	during most of w d)	rorking	State of	Maryland
Maryland	uld be filed fental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last, Nicholas Gayo)			18. Mother's N Margar	_{ame (First, Middle)} et Tasch	, Maiden Sumame)	
	ind 2 shor alth and N 27 ie ma er treuma		19a. Informant's Name/Relationship (Perry Darby Exec	Type, Print) Cutor	19b. Maili 250 V	ng Address <i>(Street</i> V. Pratt	and Number or I Street	Baltimor	er, City or Town State e, Marylar	ad 21202
Baitimore,	nit. Pages 1 and bartment of Healt cortant: If item 2: Injury or other is.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crei	osition (Name of matory or other pla edral Cem	etery 1,	Date /23/04	20c. Location - City Baltimor	or Town, State ce Maryland
Balti	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Licen	NS86		2. Name and Addre	C		edale Funer ale Marylar	
Ĭ,			23a. Part1. Enter the disease, or comshock, or heart failure. List only	pfications that caused the dea one cause on each line.	th. Do not ent	ter the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition resulting in death)	· Acute 1	Myoc	ardial		action		Onset and Death
H	/Medical Examiner		Todaling in dealin,	b. ATVL TO S	quence bf):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as a consec	quence of):	-0				
	ecuted and transit	Examin	Cause (Disease or injury that inflated events resulting in death) Last	· Horite	1284	fferen	cu			
8760,	ate be executed hysician and the burial-transit	icai	· ·	Due to (or as a consec	querice or).	UP				
X 68	entific ding p	/Мес	fF FEMALE:	23c. ff yes, outcome of pregn	ancy					
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ds, P	uires that the de signed by the a lid be detached t	by	Part If. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	5.7	to the cause of death? Probably 4 Unknown
Records,	hysician: The law requires that the his certificate has been signed by the director, page 2 should be detache.	Completed						24a. Was auto perfo	an 24b. Were prior to death	
Vital		BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	-	
	hysic his ce il dire	2	1 Yes 2 No		ER/Outpatier	IL 3 DOA	her: 4 🗆 Nursing		dence 6 □Other (S	pecify)
Division of	ending P sath. or: After t he funera	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	1	28b. Time o fnjury	Wo	ryat rk?]Yes 2 □ No	28d. Describe	how injury occurred	
Š	itei or Att rs after d rei Direct led in by I		3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, st fy)	reet, factory, office		28f. Location (: City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerei Director: After this certifical completely filled in by the funeral director,	Medical	(Check only 2 ☐ Medical Examone)	nysician: To the best of my kni miner: On the basis of examina and manner stated.	owledge, deat ation and/or in	vestigation, in my	opinion, death oc	ce, and due to the curred at the time,	date and place, and d	ue to the cause(s)
)	To To	2	29b. Signature and title of certifier	A		29c. Licen	8535		29d. Date signed (Mo	Onin, Day, Year)
	V		30. Name and address of person who	Rixen 9	101 Fr		quare Dr	ive Rosed	lale Maryla	and 21237
R	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 1 200	32: Registrans Sign	ature	we .				
				78"	6					

		1 - State Amend Item 25, 1. Decedent's Name (First, Middle, Last)	<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		200	2. Date of D	Reg. No.		3. Time of Death
Physici /Media		MARAM	GSC	wind			Month	1 Ce 3	2004	1026 m
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Funeral Director		012 10 1211		ln yrs. last birthday) 83 Yrs.			lin. Aug 2,	irth Day, Ye <i>ar)</i> 1920	9. Birthpla Count Mar	ace (State or Foreign ry) ryland
nyland how		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10	d. Inside City Limits
Ba-fa	scto	J 1	re	R	eisterst	own				1 ☐ Yes 2 🛣 No
with the or 2	Dir					136		1		ry?
death	nerai	11. Marital Status 12.	Was Decedent Eve	er in U.S. 13.			(Specify Yes or N	lo- 14. Ra	ace - America	
ours after ral', or its Exemin	þ	1 Never Married 2 Married	l □Yes 2K No fYes, Give				eno rican, etc.)		ifu	tc. Thite
natu	etec	15. Decedent's Education (Specify only highest grade co	n m <i>pleted)</i>	(Give	kind of work done	during most of	working	16b. Kind of	Business/Indu	ustry
within them them	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)					0	77	
0 0	a)	17. Father's Name (First, Middle, Last)		П	ousewile		Name (First, Middle			
	To B	Emil E. Enge	lskirch			Aı	nna Marie	Griner		
2 sho and h la ma auma		19a. Informant's Name/Relationship (Type,		19b. Mailir	ng Address (Street					Code)
l and 1ealth om 27 cher tr					The state of the s	Court				
8° = ₽		1 ☑Burial 2 ☐ Cremation 3 ☐ Remo		cemetery, crer	natory or other pla	, I			,	
		21. Signature of Funeral Service Licensee						Wald	orf,	Maryland
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		> Stephen M	Jenke							
K. asse.		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the						/	Approximate Interval Between
nysician		Immediate Cause (Final disease or condition	Respi	aton	4 1a	eller	2			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of);	4	A 4 5	hallman		dica	- 0'
y Alas The	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):	4 rucil	lle	Mul	vaup	cufe	ask
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cien ar	el Ex	resulting in death) Last	Due to (or as a o	onsequence of):						
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ne attending ed for use a	sician/M	in the past 12 months?	Live birth 2 [Fetal death 3		у				y ay Year
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en signe	ρ	- Diabeles 19	ellel	loc resulting in the un	aderlying cause giv	ven in Part I.				cause of death?
as be	plet	Glalicomo	·						Were autops	y findings available pletion of cause of
cate h							perfo 1 ☐ Yes	ormed?	death? 1 ☐ Yes 2	
certif	Be c	examiner? v	tal:	a to the same	Oth					
ar this eral di	i T	1 192 5 140	a. Date of Injury	28b. Time of	28c. Injur	y at				
oath. or: Aft	atio	2 Accident Investigation	(Month, Day Ye	ear) Injury						
after de Directo	ertific	3 Suicide 6 Could not be determined	Be. Place of Injury building, etc. (S	- At home, farm, stre Specify)	eet, factory, office		28f. Location (City or To	Street and Numi wn, State)	ber or Rural F	Route Number,
24 hours le Funeral	dicalC	Check only 2 medical Examiner:	On the basis of ex	amination and/or inv	occurred at the tirestigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as state and due to th	ed. ne cause(s)
within 2 To the complet	ž	29b. Signature and title of certifier	fe_		29c. Licens	e number		29d. Pate signe	ed (Month, Da	y, Year)
1										
n		30. Name and address of person who comple	ed ause of death	(Item 23a) (Type, F	Print)	eds	Dr. S.	wite,	101) 1 7
Sta		TAHOOLA KAU 31. Date filed (Month, Day, Year)	32. Registrar's	20,00	Print)	eds.	Perti	uite,	10/	1117
Star Registra	ar	TAHOORA KAU	32. Registrar's	20,00	Cools	eds.	Ferti	cute,	10/21	1117
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Thomas Grimes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

04-051	18	i lease i	State of Maryland / Dep				
AKG		1 - For State Registrar		ertificate of Death		Reg. No.	01209
	-	Decedent's Name (First, Middle, Last,			2. Date of De	ath	3. Time of Death
Physicia		Thomas S	. Grimes Jr.		Janua:	Day Yeer	4:02P ^M
/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dee	th	4c. County of Dee	
_		University Hosp	ital	Baltimore			
Funeral		5. Social Security Number 6. Sec	14 001	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Bird (Month, Da	th y, Year) 9. Bir 1,1982	thplace (State or Foreign ountry)
Director		Usual Residence of Decedent	JM 2LIF ZI Yrs.		June	1,1982	MD
land ow		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
Many	tor	MD	Baltim	ore			1 Yes 2 □ No
h the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Whal C	ountry?
23a c	alD	1931 Lauretta	Ave.	21223		U.S.A.	
r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No		
S afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2X No	1 ☐ Yes 2 ☐ No Specify:		Specify: B1	•
Pour le le le le le le le le le le le le le	ed b	15. Decedent's Edu	Year or Dates:	edent's Usual Occupation		16b. Kind of Business	
ING 21213-UU35 be filed within 72 hours after death with the Maryland ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examinational be notified at	Completed	(Specify only highest grad	e completed) (Giv	ve kind of work done during most of wo . DO NOT use retired)	orking	TOD. NAIG OF BUSINESS	midustry
d with	mo:	Elementary/Secondary (0-12) 12	College (1-4or 5+)	unknown		unknow	n
be filed trial Hyging of other	Be (17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle,	Maiden Sumame)	
Should be not Ment in marked	2	Thomas S. Gr	imes Sr.	Monte	eray Gi	rimes	
2 6 2 8		19a. Informant's Name/Relationship (Ty		iling Address (Street and Number or R			
C = M L		Monteray Grimes 20a. Method of Disposition	(mother) 1932	Lauretta Ave.	Baltin		_
		1 XBurial 2 Cremation 3 R	comoton, or	amatani or other place)	23-04	20c. Location - City or	iown, State
Baltime permit. Pag Department Important: It any injury o	3	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensi	1	22 Name and Address of Eacility	-		
Depart any in a		E.N.Walker J	c. Alance I	22. Name and Address of Facility Estep Bros. Fun 1300 Eutaw Plac	eral	ervice P.	A .
		23a. Part1. Enter the disease, or compl	ications that caused the death. Do not ene cause on each line.	nter the mode of dying, such as cardia	c or respiratory ar	rest,	Approximate
Physician		tmmediate Cause (Final		nd of chest			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	no of chest			
Examiner		Sequentially list conditions					
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dise to (or as a consequence of):				
/ bU, le be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
/ 6U, e be ex /sician e buria	calE		, ,				
Ords, P.O. BOX 08/1000 requires that the death certificate een signed by the attending phy hould be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy			23d. Date of del	iverv
death death d for	icla	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
T.C.	hys	9 Unknown	9□ Unknown				
	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to	4
w requires to been signer should be	ted				1 🗆 Y	'es 2 □ No 3 □ Pr	obably 4 \Unknown
S S S S S S S S S S S S S S S S S S S	Completed				24a. Was autop	sy prior to	topsy findings available completion of cause of
_ ⊢ ag ag	S				1 💢 yes		2□ No
OT VITAI HE Physician: The la this certificate ha rat director, page 2	Be	25. Was case referred to medical examiner?	lospital:	Othor	ath Check onl or		
Phy Phy at digital dig	1: To	1 Yes 2 No	28a. Date of Injury 28b. Time	all 30 DOA 40 Nuising i		ence 6 Other (Speciow injury occurred	pify)
JIVISION I or Attending I after death. Director: After	tlor	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? D M 1 Yes 2 No	Subject		r
VISIO Attendi	Hice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al home, farm, s	street, factory, office	28f. Location (S	treet and Number or Ru	ral Route Number,
DIVISION spital or Attending ours after death. neral Director: After filled in by the funer	Certification:	* A Trothicide	building, etc. (Specify)	eet	Lauretta	m. State) 1900 bl	ock of
lospii hour uner	edical	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, deaner: On the basis of examination and/or	ath occurred at the time, date and place	and due to the o	ause(s) and manner as	stated
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medi	Une)	and manner stated.				
or co		29b. Signature and title of certifier	m. D	29c. License number	2	29d. Date signed (Monti	n, Day, Year)
3				O.C.M.E.		January 19,	2004
0		30. Name and address of person who co			D=1++		7 0000
> Star	e	31. Date filed (Month, Day, Year)	32. Registrar's Ignature	111 Penn Street,	Baltimo	ore, Maryla	nd 21201

DHMH 17 Rev 1/2001

Registrar

32. Registrar's algnature

2 1 2004

			For State Registrar	State of Ma	aryland / Depa	artment of H rtificate of L			ene 004	01210
	Physicia		1. Decedent's Name (First, Middle, Last)	REE				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give Northwest Hospi			4b. City, Town, or Randal	Location of Dea		4c. County of Death	
	uneral irector		5. Social Security Number 6. Security 8. S		e (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days			Year) 9. Birti	nplace (State or Foreign untry) SC
Maryland	f show		Usual Residence of Decedent 10a. State 10b. County MD NA		10c. City, Town or Lo			-		10d. Inside City Limits 1 □XYes 2 □ No
th with the	23e or 28a ist be notifi	al Director	10e. Street and Number 4032 Boarman Ay	7e		10f. Zip Code	215	100	g. Citizen of What Co	
:1215-0036 within 72 hours after death with the Maryland	in reason and search systems are the search	by Funeral							14. Race - Ame Black, White Specify: B	
21215-0036 ad within 72 hours aft	nen "natura Mazlical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	uring most of wo		6b. Kind of Business/l	Industry
CA B S	ced other th	Be	11th grade 17. Father's Name (First, Middle, Last) Peters Holmes	na	<u>B</u> a	ar Maid		me (First, Middle, Ma Wilkers		
≥ ≥ €	27 is marked or traumatic ev	욘	19a. Informant's Name/Relationship (Ty Jessie Brady-Da				and Number or R		City or Town, State, Z	Tip Code) 215
altimore, Mamit. Pages 1 and 2	ant: If item ary or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20b. Place of Dispo cemetery, cres Baltimo	natory or other place	-		oc.Location-City or Saltimore	
Balt permit.	Important: If i eny injury or one		21. Signature of Funeral Service Licens	wich	4:		sh Ave	, Baltim		21215
	sician ledical	Q T	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	ne. Brovascu	7627			st,	Approximate Interval Between Onset and Death
	nysician and he burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as	a consequence of): a consequence of): a consequence of):					
P.O. Box 68	ted by the attending phase detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	been signed b should be deta	þ	Part II. Other significant conditions col	-	out not resulting in the u	nderlying cause give	on in Part I.		acco use contribute to 2 □ No 3 □ Pro	the cause of death?
E SE	ate has page 2	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 ₺	ed? prior to o	topsy findings available completion of cause of
of Vita Physician:	is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatier	nt 3□ DOA Othe		ath <i>(Check only one)</i>) ace 6 ⊡Other <i>(Spec</i>	rify)
Z giff	After th funeral	atlon; T	27. Manner of Death 1 ⊠Natural 5 □ Pending investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time o	f 28c. Injury Work	at	28d. Describe how		,,
Division oital or Attending	Within 24 hours aren dean To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	building, et	ury - At home, farm, st c. (Specify)			City or Town,		
the Hospital	the Fune	Medical	(Check only 2 Medicel Exemi one)		of my knowledge, deat f examination and/or in ated.		inion, death occ	urred at the time, dat		to the cause(s)
2	70 CO		29b. Signature and title of certifier	15.S.NA		04	3463	50	ANUARY	17,2004
			30. Name and address of person who con S 6 2 - LIS FRT 31. Date filed (Month, Day, Year)	T PLA	2 A TT A L	L RAP	VOAL	CST0W.	A MID	21113
	Sta Registr		31. Date filed (Month, Day, Year)	2 1 2004	ars agnature	H Aparl				

State of Maryland / Department of Health and Mental Hygiene 2001 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 4:45 AM 2004 18 Clifton Gordon, January Jr /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country)
 N C **Funeral X**□M 2□F Days N.C. Vrs Director 239-50-7341 67 7-16-1936 Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 TYPes 2 □ No Md N/A**Baltimore** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3007 Virginia Avenue 21215 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. National Security Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A Machine Operator Agency Forte Meade permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clifton Gordon Leida Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) <u> Catherine Gordon - Wife</u> 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 1/24/2004 Catonsville, Md 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licens#e 4300 Wabash Avenue Balto, MD 21215 23a Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aortic Dissection **Physician** 3 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2200 1 ☐ Yes 2 7 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 patient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) whol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinkov 4108 Avenue. Roland ladimir 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, F. Gratz 2004 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore Johns Hopkins Bayview Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 13,1946 7. Age (In yrs. last birthday) 5. Social Security Number 1 XM 2□ F 57 Yrs. MD. 214-50-0228 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 8101 Longpoint Road

Physician

/Medical

i Director

10a. State

MD.

Examiner

Funeral

Director

Ph // Ex	y: Ne	sic ed mi	ia ic in	in a'
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To the Hospitel or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physicien and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Division of Vital Records, P.O. Box 68760,

1 =												
lue		Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spec an, Mexican, Puerto P	city Yes or No- lican, etc.)	14. Race - Ame Black, White						
N Y	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give	1 ☐ Yes 2 📉 No	Specify:		Specify: 147b	4+0					
P	3 Widowed 4 Divorced	Year or Dates:				. W11	ite					
ete	15. Decedent's Educ (Specify only highest grade		 Decedent's Usual Occup (Give kind of work done life. DO NOT use retired 	during most of workin	g 16b. i	Kind of Business/	Industry					
Completed by Funer	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	Sergent	2)	Spar	rows Point	t Police					
BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)											
10E	Joseph Gratz											
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	Patricia Gratz	wife 8	101 Longooin	t Road, Du	undalk,Md.	21222						
	20a. Method of Disposition	comoto	of Disposition (Name of ary, crematory or other place	Janua	ite 20c. l	ocation - City or	Town, State					
	1 ☐ Burial 2 【XCremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)		ew Crematory	1	_	timore C	ity, MD.					
	21. Signature of Funeral Service License		22 Name and Addre	Funeral Ho	me Of Dun	dalk,P.A	797%					
	many C	- onnerey		ers Point		dalk, Mo						
ı	23a. Part1. Enter the disease or complice shock, or heart failure. List only one	e cause on each line. Metastatic		Cancer			Approximate Interval Between Onset and Death					
	Immediate Cause (Final disease or condition resulting in death)			5 months								
	resulting in death)											
<u>_</u>	Sequentially list conditions b. Oue to (or as a consequence of):											
Jine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	cause. Enter Underlying Cause (Disease or injury										
xan	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):									
a E			,-									
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/Me	IF FEMALE:	c. If yes, outcome of pregnancy				23d. Date of deli	NAD.					
ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	′		Month	Day Year					
ıysi	1 Yes 2 No 9 Unknown	9□ Unknown	_ ,, ,, _									
Completed by Physician/Medical Examiner	Part II. Other significant conditions cont	ributing to death but not resulting i	in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?					
d b					1 ☐ Yes 2	2 → 3 □ Pro	obably 4 Unknown					
iete					24a. Was an	24b. Were au	topsy findings available					
dmc					autopsy performed?	prior to d death?	completion of cause of					
CO	25. Was case referred to medical			26. Place of Death	(Chack apply and	o 1 □ Yes	2□ No					
100	examiner?	ospital:	utpatient 3 DOA Oth	or	e 5 Residence	6 Other (See	2/64)					
To To		28a. Date of Injury 28b.	Time of 28c. Injur	y at 21	8d. Describe how inju		ary)					
fication:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wor M 1 □	k? Yes 2 □ No								
fica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28	8f. Location (Street a	nd Number or Ru	ıral Route Number,					
Medical Certi	4 Homicide	building, etc. (Specify)			City or Town, Stat	e)						
alC	29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge	e, death occurred at the tir	ne, date and place, ar	nd due to the cause(s	s) and manner as	stated.					
dic	(Check only 2 Medical Examin one)	er: On the basis of examination ar and manner stated.	nd/or investigation, in my o	pinion, death occurred	d at the time, date an	d place, and due	to the cause(s)					
Me	29b. Signature and title of pertifier	(1)	° 4 29c. Licens	e number	29d. Da	ate signed (Month	n, Day, Year)					
1	K Kobert Non	eran Uncologe	Dog	656919		01/21/	04					
	30. Name and address of person who cor	mpleted cause of death (Item 23a)	(Type, Print)	•			•					
	Robert Dunea	6 B	mc Sul	re 205								

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			For	State of Mary	land / Dep	artment of H	Health and			
			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	74 01610
	- 1		Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physicia		CHARLENE			GRIFF	IN	JANUA	Y13 ZO	04 11:05 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	th	4c. County o	f Death
	CAGIIIII	ÇI			spite)	Baltin	nove.		NA	
			5. Social Security Number 6. Se	-170.00	yrs. last birthday			8. Date of Birt	n	9. Birthplace (State or Foreign
	Funeral Director			DM 2/ X F	Yrs.	Months Days	Hours Min	8. Date of Birt (Month, Day 6-21	, Year) -30	Country) Md
	Director		Usual Residence of Decedent	64				0 21		110.5
	land bw		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Aary f sh	ō	Md NA		Balti	more				Yos 2 □ No
	he 28a-	Director	Md NA 10e. Street and Number		Daren	10f. Zip Code			10g. Citizen of Wi	had Country?
	with so a	ក្ន				1	224		USA	nat Country!
	death with the Maryland ma 23a or 28a-f show	Funeral	1429 Demancy Way							
	er de	nne	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Hace Black	- American Indian, , White, etc.
0	or I		1 Never Married 2 Married	1 □Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	Black
2-003p	hours atter lural', or Ite	d by	3 Widowed 4 Divorced							
ភ	72 r	ete	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	16a. Deci	edent's Usual Occup e <i>kind of work don</i> e DO NOT use retire	pation <i>duri</i> ng most of wo	orking	16b. Kind of Bus	iness/Industry
V	ithin	п	Elementary/Secondary (0-12)	College (1-4or 5+)	/ife.	DO NOT use retire	id)	i		
N	filed within 72 Hygiene. Ither then "nai	Completed	8th grade		Do	mestic				ople Home
2		Be	17. Father's Name (First, Middle, Last)	D 1	2			me (First, Middle,	Maiden Sumame Smit	-
yland		၉	Leonard	Dode	a		Rachel	<u> </u>	Silit C	.11
Mar	d 2 should be th and Mental 7 Is marked traumatic ev		19a. Informant's Name/Relationship (T)	γρe, Print)	19b. Mai	ing Address (Street	and Number or R	ural Route Numbe	r, City or Town, S	itate, Zip Code)
	2 = Z		Michele Dodd	Daughter	5	14 W. Pre	eston St.	, Baltim	ore, Md.	21201
ē,	- F 5 5		20a. Method of Disposition		Ob. Place of Disp	osition (Name of ematory or other pla	ce)	Date	20c. Location - C	City or Town, State
Baitimor	Pages nent of int: If It		* 4 Doquation 5 ☐ Other (Specify)	Removal from State			1-20	0.04	Lansdowr	5M oc
	artm ortar injur		21. Ignature of Funeral Service Licens		Mt. Zio	22. Name and Addre				
n	permit. Pages Department of I Important: If It any injury or o		Lesich R.	Matten	1		,		ore, Md.	
2		_	23a Pa 1. Enter the disease, or comp s ock, or heart failure. List only o	lications that caused that	AY Do not er	March F.H	. Last	TIUI E.	North A	Approximate
			s ock, or heart failure. List only o					o or rospilatory ar	031,	Interval Between Onset and Death
	Physician		Immeriate Cause (Final dise se or condition resulting in death)	a Intrac	vanial	hemov	rrhage			3 days
	/Medical Examiner		rocating in county	Due to (or as a cor	nsequence of):		O			
	LAGITIMIC)	_	Sequentially list conditions,	b						
,	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	istiquence of).					-1
	nd	am	that initiated events	c.						
90,	be executed ician and burial-transii		resulting in death) Last	Due to (or as a cor	nsequence of):					
	e s	cal		d.						
ğ	death certifica e attending ph d for use as th	Physiclan/Med	The second of							
ŏ	n cer	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		□C-+ -			23d. Date	of delivery
מ	d for	icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2□ 4□Pregnant at time		□Ectopic pregnanc □ Other <i>(specify)</i> _	у		Mont	h Day Year
j.	the y th iche	Jys	9 Unknown	9□ Unknown						
7	requires that the dei neen signed by the a hould be detached fo		Part II. Dther significant conditions co	ntributing to death but no	t resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
cords	sign d be	d by						1 🗆 Y	es 2 □ No 3	Probably 4 Minknown
Ö	ned nou	Completed								
ě	60 50 50	ldu						24a. Was a autop	sy pri	ere autopsy findings available for to completion of cause of
=	ate pa	Ö						perfor 1 ☐ Yes		ath? Yes 2 No
VIII	ysician: Th is certiticate director, pag	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only of	19)	
	S S D	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	ner: 4 Nursing I	Home 5 Resid	ence 6 Other	(Specity)
0	iding Ph Ih. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time Injury	of 28c. Inju	ry at	28d. Describe h	ow injury occurred	d
<u></u>	ndin ath. r: Ath	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(,,		Yes 2 □ No			
UNISION	spital or Atten ours atter deat neral Director: tilled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, s	treet, factory, office				or Rural Route Number,
5	alte Dir din l	ert	4 Homicide	Building, etc. (5)	овспу)			City or Tow	n, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely tilled in by the funer		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my	knowledge, dea	th occurred at the ti	me, date and place	e, and due to the o	ause(s) and man	ner as stated.
	To the Hos within 24 h To the Fur completely	edical		iner: On the basis of exa and manner stated.	mination and/or i	nvestigation, in my	opinion, death occ	urred at the time, o	late and place, an	nd due to the cause(s)
	ithin the omple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed ((Month, Day, Year)
	- 3 F 8			Mum	MDIA	0 0-	5-00		_	10
	2		0.100			1,40	3-00	,	January	13,2004
			30. Name and address of person who c			, Print)	Δi	3 141	10 1	1 71710
						enshaw	Mace L	Beltimore	Micryland	1 21218
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registar's S	agnature 34	Soul ?				

ADH GREGORY GREEN 04-0451

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	<u>ا</u>	State of State of State Unpend Item #23a,27,28a-1 Registrar Decedent's Name (First, Middle, Last)	per me doze	ntificate of Death	Reg.	No. 4 4 4	UIZ
Physician	, ě.	Gregory Green			Month JANUARY	Day Year	3. Time of Dea
/Medical Examiner		a. Facifity Name (If not institution, give street and num	ber)	4b. City, Town, or Location of De		16, 2004 4c. County of Death	0940 A
		1504 E. MADISON AVENUE		BALTIMORE CITY		NA	
Funeral Director	L	216-56-7953 10M 20 F	Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birth	place (State or Fo
Mo Wi	-	Isual Residence of Decedent Oa. State 10b. County	10c. City, Town or Lo	ocation /			10d. Inside City L
tor 28a-fatte be notified	/	Maryland N/A		Baltimore			1 ∀ Yes 2 [
		0e. Street and Number 5614 Elderon Ave	•	10f. Zip Code 2/2/5	10g.	Citizen of What Cou	ntry?
rai', or items 23s		1. Marital Status 1. Mover Married 2 Married 3. Widowed 4 Divorced 12. Was Deced Armed Force 1 Yes, Give Year or Date	: Wo	Was Decedent of Hispanic Origin? If Yes, specify Cubar, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White, Specify: DL	
"natural",		15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking 16t	. Kind of Business/In	ndustry
of other than "naturi event, the World It Be Completed	_	Elementary/Secondary (0-12) College (1-4	for 5+)	ome Improvem	ent	524-2	mploxe
d otl		7. Father's Name (First, Middle, Last) Robert Green, Jr.			ame (First, Middle, Mail		
		9a. Informant's Name/Relationship (Type, Print) Rubin Grzen - Sister	19b. Mailir 2025	ng Address (Street and Number or	Rural Route Number, Ci	ty or Town, State, Zip	Code) 21
r Heatth Item 27 other tr	2	0a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date 200	Location - City or To	cy Grand
nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St '4 ☐ Donation 5 ☐ Other (Specify)	ate Localine	natory or other place)	123/04 N	loodlawn	Many
Department of Hea Important: if item any injury or othe once.	2	11. Signature of Funeral Service Licenses Hintel		Name and Address of Facility P		Himore, N	GNE F.S.
g physicien and as the burial-transit as the burial-transit edlcal Examiner	i di	sequentially list conditions, any, leading to immediate Due to (or ause. Enter Underlying ause. (Disease or injury aut initiated events c.	as a consequence of): as a consequence of): as a consequence of):				
d by the attending perached for use as Physiclan/Mec	11 2		h 2 Fetal death 3 nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive	ory Day Yea
be o		art ff. Other significant conditions contributing to dea	th but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	N. C
itilicate has been si for, page 2 should I e Completed					24a. Was an autopsy performed Yes 2 □	prior to cor death?	psy findings avai impletion of cause 2 No
direct		5. Was case referred to medical examiner? 1 XYes 2 No Hospital: 1 Inp	atient 2 ER/Outpatien	Othor	eath (Check only one) Home 5 Residence	6X Other (Specifi	AT SCE
	2	7. Manner of Death 1 Natural 5 Pending 1 Natural 1 1 Natural 5 Pending 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	fnjury 28b. Time of Day Year) 9:30 njury	28c. Injury at Work?	28d. Describe how in		,
ed Director: After led in by the funera Certification;		2 Accident Found found	found Injury - At home, farm, stre , etc. (Specify)	a 1 ☐ Yes 2 X No eet, factory, office	281. Location (Street City or Town, St	and Nursher or Rura ate) 1504 E. M	l Route Number adi Son "Ave
5 € = -	2	9a. Certifier 1 Certifying Physician: To the base	n vacant dwelli est of my knowledge, death is of examination and/or inv	accurred at the time, date and place	Baltimore, M	aryland	
To the Fune completely fill	3	one) and manner 3b. Signature and title of certifer	r stated.	estigation, in my opinion, death occ			
	,	· M.	le -	OCME		Date signed <i>(Month, I</i> NUARY	oay, rear)
DU	3	D. Name and address of person who completed cause	of death (Item 23a) (Type, I	orint) 111 Renn Stre	et Baltim	ore Marvl	and 2120
1		TATEUR THE TRUMP TENTY					

			1 - For Amend Item #78 Registrar	18 State of Maria	aryland/ Depa Cei	artment of F rtificate of	lealth and M <i>Death</i>	ental Hygie Reg.	ne No. 2001	+ 01215
			1. Decedent's Name (First, Middle,					2. Date of Death	Day Year	3. Time of Death
6.0	Physici /Medio		BYRIN B (ZADDRIII)					JANUARY		4 0600 M
	Examir		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. County of Dea	
	·		804 JACK STREET 1FL #B			BALT If Under 1 Year	BALTIMORE			
	Funeral				e (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) C	thplace (State or Foreign ountry)
dia -	Director		219-52-8095 Usual Residence of Decedent	<u> </u>	55 Yrs.	L		01-28-1	949 M	D
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f s	ctor	MD N/A		BALT	IMORE				1√2 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	ath w		804 JACK ST,	1ST FL #	B		21225 lispanic Origin? (Spe		USA	
	er de Items	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	hours after death with the Maryland turst', or items 23a or 28a-f show of Ezaricher must be notified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 □ N If Yes, Give X Year or Dates:	40	1□Yes 2□No	Specify:		Specify:	BLACK
21215-0036	72 hou natura dicel E		15. Decedent's	Education	16a. Deced	dent's Usual Occup	ation	161	. Kind of Business	
215	within 7; ene. then "n	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	lite. I	kind of work done DO NOT use retired	during most of worki d)	ng		
21;	ygiene ygiene ner the	Completed	12	Joine Go ()		iver		T	ranspor	tation
nd	II H	Be (17. Father's Name (First, Middle, La	ast)			18. Mother's Name Leatha W	(First, Middle, Mai 1111ams	den Sumame)	
yla	should by and Menta i marked umatic even	2	Leonard Garre				Leathe	r Willi		
Maryland	a is a	1	19a. Informant's Name/Relationshi	p (Type, Print)			and Number or Rura			
	s 1 and if Health item 27 other tr		Judith Garret 20a. Method of Disposition	tt, Wife	20b. Place of Dispo		, 1st Fl		to Md . : Location - City or	
Baltimore,	Pages nent of i		1 ☐ Burial 2 ☐ Cremation 3		cemetery, cren	matory or other plac	(e)		·	
	그는 원급		 4 □ Donation → 5 □ Other (Special Signature of Funer Pervice Li 			Cremato:			MARYLANI	
Ba	Depa Impo eny ir		11/11/10 8	officel			ss of Facility How			me <u>Md. 21207</u>
e.	0.00		23a. Part1. Enter the disease, or c	omplications that caused	the death. Do not ent					Approximate
25	Physician		shock, or heart failure. List or Immediate Cause (Final							Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)		stitial] a consequence of):	Pulm Fil	orosis			1995
в	Examiner			Rheum	atuid Ar	thritis				1992
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					222
	ocuted nd transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	monary H	ypertens	sion			2003
30,	oe execian a		resulting in death) Last		a consequence of): MI					
8760,	cate be executed physician and the burial-transit	dical	•	d						
9 X		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy			-1	T 004 Data 444	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	•		23d. Date of de Month	Day Year
o.	that the de ned by the a detached f	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		_ = = = = = = = = = = = = = = = = = = =				
۵.	requires that the death certifi seen signed by the attending hould be detached for use as		Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	quires n sign	d by						1 ☐ Yes	2□No 3□P	robably 4 Unknown
S	≥ 1 °	pieted						24a. Was an	24b. Were a	utopsy findings available
Re	o ~ ~	ompi						autopsy performed	? death?	completion of cause of
Vital Records,	i cian : Th certificate rector, pag	9	25. Was case referred to medical				26. Place of Death	1 Yes 3₹3 (Check only one)	(40) 1010	
ţ <	8 % E	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	nt 3 DOA	er: 4 🗌 Nursing Hor	ne 5 hesidence	e 6 □Other (Spe	city)
n of			27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Inju (Month, Day	ry 28b. Time of Injury	f 28c. Injur Wor	y at k?	28d. Describe how i	njury occurred	
sio	Attending r death.	catl	2 Accident investiga 3 Suicide 6 Could no			M 1 🗆	Yes 2 □No			
Division	l or Attendater death Director:	Certification;	4 Homicide determin		ury - At home, farm, str c. (Specify)	eet, factory, office	1	28f. Location (Stree City or Town, S		ural Route Number,
	Hospital		COn Continue 1 Continue	Physician To the best	of my knowledge, doesn	b annumed at the time	an data and alam	and also to the second	- (-)	
1	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of xeminer: On the basis of and manner sta	examination and/or inv	vestigation, in my o	pinion, death occurre	ed at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and wife of certifier	1-	0 01	29c. Licens	e number	29d.	Date signed (Mont	h, Day, Year)
	7-0		> Cfilano	I amo	1 Stol	/ D21	930		1/6/200	4
	j V		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type,	Print)				
_	7		E. James Brit	t MD Univ	Of Md Me	ed. ctr.				
	Sta		31. Date filed (Month, Day, Year)	2 1 2004 Regist	s Signature	Small !				
	Regist	ar	AUIA	7	Back Market Mark	1				

			1_ For		ryland / Depa	artment of H	lealth and	•	_	01216
			Registrar		Ce	rtificate of l	Death		eg. No.	· UIGII
	Physici	an	Decedent's Name (First, Middle, Last)					Date of Deat Month	Day Year	3. Time of Death
	/Media		POLY			GILLER		JANUARY		6:15 A M
1 000	Examir	ner	4a. Facility Name (If not institution, give s		_	4b. City, Town, or		th	4c. County of Death	
			JEWISH CONVALESC			BALTIN			BALTI	
į	Funeral Director		21/-92-3002	7. Age M 21XF 9	(In yrs. last birthday) 4 Yrs.	Months Days	If Under 24 Hrs Hours Min.		9. Birth UKRA	nplace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	he Mary 28a-f sho	ector	MD BALTIMORE		BALTIMORE					1 ☐ Yes 2 💢 No
	23a or 2	ral Dir	7920 SCOTTS LEVEL	ROAD		10f. Zip Code 21208		US	0g. Citizen of What Co SA	untry?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Examinar must be Indiffed at or other traumatic event, the Medical Examinar must be indiffed at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White WH Specify:	
Maryland 21215-0036	thin 72 ho e. en *natu		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Business/I	ndustry
2	ed wil	Son	12			CURIST			NAIL CARE	
land	uld be filed fental Hygir rked other tic event, I	To Be C	υ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, M 19. NAMICI EICENDEDC VETTA EI						Maiden Surname) SENBERG	
	and 2 should ealth and Men n 27 is marke		19a. Informant's Name/Relationship (Typ MR. BORIS GILLER/SO						City or Town, State, Z.	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item eny injury or othe once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ri 1 □ Donation 5 □ Other (Specify)	emoval from State	ARE THE TOP	sition (Name of tratify by a Markelac VGREGATTOI	N 1/18		BALTIMORE, M	
Baltii	permit. F Departme Importar eny injur		21. Signature of Funeral Service License	96	22	2. Name and Address	ss of Facility	SOL LEVIN	SON & BROS	., INC.
			23a. Part1. Enter the disease, a complic shock, or heart failure. List only on	cations that caused t					PIKESVILLE	Approximate
樂	Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Fhal disease or condition resulting in death)	ALZ	consequence of):	RD-	-S.			Interval Between Onset and Death
	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o s a	cons uence of):	HON	32010			
,09	e be executed /sician and e burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that infilted events resulting in death) Last c. Vie to (or as a consequence of):							
687	A × 6		d							
Box	The law requires that the death certificate lie has been signed by the attending phy age 2 should be detached for use as the	Physiclan/Med	in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					23d. Date of deliver Month	very Day Year
<u>о</u>	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions con		ant requiting in the	adashina sawa awa	an in Daniel	220 Did tob		bha agus of doub?
Records,	w requires the been signer should be d	by	Part II. Other significant conditions con	tributing to death but	not resulting in the ui	nderlying cause give	en in Part I.	239. Did tob	acco use contribute to s 2 No 3 □ Pro	the cause of death? bably 4 Unknown
	The law re cate has be page 2 sho	Completed						24a. Was ar autopsy perform	y prior to co negt? death?	opsy findings available ompletion of cause of
Vital			25. Was case referred to medical				26 Place of Dog	1 ☐ Yes 2	No 1 Yes	2 No
>	Physician: this certifica ral director, p	o Be	examiner?	ospital:	t 2 ER/Outpatien	t 3 DOA Cthe	ar /		nce 6 □Other (Speci	4.1
ō	Phy or this oral o		27. Manner of Death	28a. Date of Injury	28b. Time of		The second secon	28d. Describe ho		<i>TY)</i>
o	ding th. Afte fune	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		k? Yes 2 □ No		,	
Division of	al or Attending P after death. I Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number or Rur , State)	al Route Number,
/	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 2 Medical Exemin	ician: To the best of eer: On the basis of e and manner state	examination and/or inv	n occurred at the time vestigation, in my op	ne, date and place pinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	o the o the omple	Me	29b. Signature and title partitier			29c. License	number	29	d. Date signed (Month,	Day, Year)
1	⊬ ≱ ⊬ 8		ill of	1000			5474	6	01/16/	ol
	1		20 Name and address of	malated assistant	oth /ltow 00 s) CT -		9///		01/10/	~ 7 .
			30. Name and address of person who con A POVOV, 68 31. Date filed (Month, Day, Year)	2 1 PC 31	23/0W/	Ed Ho	206, BO	etimer	mo 21	215
	Sta Registr		JAN 2 1 200	4 September 4	s signature	ele				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) January 19, 2004 **Physician** Catherine Heagerty 3:30 p M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year, Feb 22, 1 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Min. 1 □ M 2X F Months Davs Hours 88 1915 216-01-6877 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes ZNo Director Carrol1 Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5804 Emory Road 21155 U.S.A. within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: If Yes, Give Year or Dates: Specify: ۾ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If item 27 is marked other than "1 any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Potlatch 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Fulton Roop Sallie Leight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Heagerty (Son) 5804 Emory Road Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Emory Church Cemetery 1/21/04 Upperco, Maryland * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD chen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician /Medical Due to (or as e consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner for use as the burial-transit by the attending physician and Due to (or as P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Uoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 ∃Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 3 DOA Medical Certification; To 1 🗌 Yes 2 ER/Outpatient this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending Injury death. investigation 2 🗋 Accident To the Hospital or Attendation 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 139502 MI 30. me and address of person who co pleted cause of death (Item 23a) (Type, Print) Thus 20 Magistrar's Signature. 31. Date filed (Month, Day, State Registrar

		1 - For State Registrar	State of Ma	ryland	/ Depa		of H	ealth a				004	01218
Dharist	42 ⁻²⁵	1. Decedent's Name (First, Middle, La	ist)						}	2. Date of Dear Month	th Day	Year	3. Time of Death
Physicia /Medic		Russe11		Har	nme					January	21,	2004	5:30 a M
Examin		4a. Facility Name (If not institution, given	re street and number)			4b. City, 7	Fown, or	Location o	of Death		4c. C	ounty of Deatl	1
		Continuum Care at	Sykesvill	e				ville				Carro1	1
Funeral				(In yrs. last		If Under	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	oplace (State or Foreign untry)
Director		214-20-2303	7: 1×1 7:	2	Yrs.					Oct 21,	193	1 Penn	sylvania
pu		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						· ·	10d. Inside City Limits
aryla sho	<u> </u>			roo. Ony, t									1 ☐ Yes 2 🖾 No
he M	Director	MD Balti	more		K	eiste		wn					
with 1		10e. Street and Number	D1			10f. Zip		26		1	og. Citize	on of What Co	•
-UU36 hours after death with the Maryland turel', or items 23a or 28a-f show at Evarrieus frontified at	Funeral		Place		40.1		211		. 0.10		1 44	U.S.	
er de Item	Š	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Endemod Forces? 1 ☐ Yes 2 ☒ No		13.	f Yes, speci	fy Cubar	n, Mexican	gin? (Spe i, Pu <i>er</i> to i	cify Yes or No- Rican, etc.)	14	Black, White	
rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	5		1 ☐ Yes 2	No 🍱	Specify:			s	pecify: W	hite
ING 21213-UU35 be filed within 72 hours after death with the Marylan lat Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evantinal matural at	pa	15. Decedent's E		1	6a. Deced	dent's Usual	Occupa	tion			16b. Kind	of Business/l	
within 72 ene.	Completed	(Specify only highest gr	ade completed)		(Give	kind of worl	k done d	urina most	of working	ng	, 001 (11110		
I with	mo	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Too	1man					B1ac	k and l	Decker
nd 21	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, M			
lan lid be fental ked o	To B	I	lenry A. 1	Hamme				E11	La	М	ay	Shue	
Maryland d 2 should be file th and Mental H; t? is marked oth traumatic avent		19a. Informant's Name/Relationship	Type, Print)	1	19b. Mailin	ng Address	(Street a	nd Numbe	r or Aura	l Route Number	City or 1	own, State, Z	ip Code)
C = 44 F		Mr. Richard Hamme	Brother	6	646 G	1ynoc	k P1	ace F	Reist	erstown	, MD	21136	6
re, land the litem 2 other		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of her place	a)	D	ate	20c. Loca	ition - City or T	own, State
altimori mit. Peges partment of t cortant: If its rinjury or of	- 9	1 ☐ Burial 2 ☑ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Speci		l .		Crema	,		1/21	/04	Ha	mpstead	d, Maryland
Baltimore, bermit. Peges 1 a Department of Her mportant: If item my injury or othe		21. Signature of Funeral Service Lice	nsee		22	. Name and	Addres	s of Facility	y 11	824 Rei		-	
n Feera		Steahen	m. fent	Lins	EL	INE F	UNER	AL HC					yland 21136
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	he death. C	Do not ent	er the mode	of dying	, such as	cardiac of	r respiratory arre	est,		Approximate
Physician		Immediate Cause (Final		/2 ha.	*		no		<i>'</i>				Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a) tin	- July 7					7715.
Examiner			_		·								
	Jer	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequen	na of)-				-				
cuted	Examiner	that initiated events	С.										
be executed icien and burial-transit		resulting in death) Last	Due to (or as a	consequen	ce of):								
y s	cal		_ d										
death certifica a attending ph	Med	IF FEMALE:											
BOX sath cer attendir for use	an/	23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pre	onancy				230	d. Date of deliv	•
o dea a dea a dea ed fo	scl	in the past 12 months? 1 Yes 2 No	4☐Pregnant at ti 9☐Unknown			Other (spe						Month	Day Year
at the lby the stache	Physician/M	9 Unknown											
	ρχ	Part II. Other significant conditions	contributing to death but	not resultin	g in the ur	nderlying ca	use give	n in Part I.					the cause of death?
equir equir sen s ould	ompleted									1 🗆 Ye	s 2 🔲	No 3∏Pro	bably 4 AUnknown
The law of the has be bage 2 sh	ple									24a. Was ar autops		24b. Were aut	opsy findings available ompletion of cause of
VICAL MECORGS, visician: The law requires is certificate has been signe lirector, page 2 should be	Con									perform 1 ☐ Yes 2	red?	death? 1 ☐ Yes	
Or VICA Physician: this certific ral director,	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
Of V Physic this co	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	t 2□ER/	Outpatien	3 DO	Othe	r: 4 🗖 Nur	sing Hom	ne 5 ☐ Reside	nce 6	Other (Speci	fy)
ION Of VICAL nding Physician: th. After this certifical funcial director,	on:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 281	b. Time of Injury	28	lc. Injury Work	at ?	2	8d. Describe ho	w injury o	occurred	
SIO tendi fleath. for: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 N					
UNISION for Attending after death. Director: Atte	Certification:	4 Homicide determined		y - At home, (Specify)	, farm, stre	et, factory,	office		2	8f. Location (Str City or Town	eet and f , State)	Number or Rur	al Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral													
Hosp 14 ho Fune Telly fi	edical	(Check only 2 Medical Exal	nysician: To the best of miner: On the basis of e	examination	dge, death and/or inv	occurred a restigation, i	t the time in my opi	e, date and inion, deatl	d place, a h occurre	nd due to the ca d at the time, da	use(s) ar	nd manner as a ace, and due to	stated. to the cause(s)
thin 2 the mptel	Med	29b. Signature and title of certifier	and manner state	au.			License					signed (Month,	
T vil	-	290. Signature and title of certifier	Man man						Į		1	/	Jay, redij
		-				-	, ,					104	
2		30. Name and address of person who	completed cause of dea	ath (Item 23	a) (Type, I	Print)			12	Rail	1./		2 31136
Sta	0	31. Date filed (Month, Day, Year)	32. Registrar			, 6		-		,	7	-n pri	~ (1/36
Registra		JAN 21		-		nach s	V						

DHMH 17 Rev 1/2001

ORIGINAL

			Please Type or Print State of Many 1- State Registrer	yland / Depa	artment of Heartificate of De	alth and M	ental Hygie	•	. 01219
	Physici /Medic	cal	Decedent's Name (First, Middle, Last) Martin Jay Hanna, III Aa. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		2 Date of Death	Day Year 20, 2004	
	Funeral Director		218-32-8387 1⊠M 2□F	e Care n yrs. last birthday) 67 _{Yrs.}	If Under 1 Year If	OWSON Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jul 2,	Baltimor 9. Bin 20 1936 Ma	hplace (State or Foreign buntry) TYLand
	death with the Maryland ima 23a or 28a-f show	Director	Usual Residence of Decedent	Oc. City, Town or Lo Cockeys v			10g	. Citizen of What Co	10d. Inside City Limits 1 Ves 2 No
200	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Manth Hygiene. If item 27 is marked other than "naturel", or Itema 23a or 28a-f show it it item 27 is marked other than "naturel", or Itema 10a notified all or other traumatic event. It a Medical Examinat must be notified at	by Funeral D	10706 Westcastle Place, #104 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 10706 Westcastle Place, #104 12. Was Decedent Eve Amped Forces? 1 Yes, Give Hyes, Give Year or Dates:	or in U.S. 13. \	21030 Was Decedent of Hispa If Yes, specify Cuban, N 1□ Yes 2□ No S	anic Origin? (Spe Mexican, Puerto F Specify:		Inited Sta 14. Race - Ame Black, Whit Specify: Whi	oncan Indian, e, etc.
	e filed within 72 hou al Hygiene. I other then "nature vent, ina Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done durit DO NOT use retired) Safety Eng	ng most of workin	9g 16	b. Kind of Businessy Public Saf	îndustry
ryland	2 should be file o and Mental Hy is marked oth raumatic event	To Be (17. Father's Name (First, Middle, Last) Martin Jay Hanna, Jr. 19a. Informant's Name/Relationship (Type, Print)	10b Mailie		Anna Wi	(First, Middle, Magley		Tin Code)
≥ ע	les 1 and 2 sl of Health and if item 27 is no or othar traur		Mrs. Janice Leister-Hanna/W	ife 1070	6 Westcast	le Place	#104, ate 20	Cockeysvi	lle, MD Town, State
Dalillio	permit. Pages Department of I Important: If it any injury or o			- i	ake Cremato Name and Address of Cremation 8717 Green	ry 2 f Facility and Fune	2004 Beral Alte	eltsville rnatives Baltimor	- 42
	Physician /Medical Examiner	10	23a. Can1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Either Underlying	onsequence of):		uch as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
,00/00	icate be executed physicien and s the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a co						
ă .	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the past 12 months? 1 ☐ If yes a continuous of the past 12 months? 4 ☐ Pregnant at time 12 months 12 m	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
acolds, r	requires that the reen signed by th hould be detache	b	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause given in	n Part I.	23e. Did tobad	A .	the cause of death?
	nn: The law r ificate has be or, page 2 sh	e Completed	25. Was case referred to medical				24a. Was an autopsy performed 1 Yes 2 (Check only one)	prior to death?	topsy findings available completion of cause of
IN IN IN	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 tompletely filled in by the funeral director, page 2.	To B	examiner? 1	28b. Time of	other: 28c. Injury at Work?	4 Nursing Hom	1	e 6 & ther (Specinjury occurred	city) Hospia
Division	pital or Atte	i Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (3	Specify)			City or Town, S		
	To the Hos within 24 hc To the Fun completely i	Medical	29a. Certifier (Check only one) 29b. Signatur, and tittle in certifier (Check only one) 29b. Signatur, and tittle in certifier	amination and/or inv	vestigation, in my opinio	on, death occurre	d at the time, date	and place, and due	to the cause(s)
	13X,	X	30. Name and address of person who completed cause advant	nc 6	Print) 701 A(-(Char	Cas St.	Balto.	n, Day, Year) 20, 2008 Md 21208
	Sta Registi		JAN 2 1 2004 32. Registry 5	Signature	9 span	Est			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death HERMAN **Physician** enneth 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 919 Arran Road Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Jan 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 59 Yrs. 1 MM 2□F 218-42-4432 Ĩ944 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No MD Director Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 919 Arran Road 21239 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Stres 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: Wh<u>ite</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 64-70 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Oual 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Quality Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mentat Hygiene.ent: If item 27 is marked other than Telecommunications Control Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Herman Doris Marie Buchal ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Norma J. Herman/Wife 919 Arran Road, Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō = 6 Jan 17 1 Burial 2 Cremation 3 Removal from State Department Importent: I any in ury o Chesapeake Crematory Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2004 permit 21. Signature of Funeral Service Lice 22 Name and Address of Facility
Cremation and Funeral Alternatives once. 8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Herratic Metastases 1 Tyes 2 □ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate has lirector, page 2 autopsy performe 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and ad Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2004 anuany 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Çiği, Town, or Location of Death Examiner TMORE (N/A144 1105 If Undar 1 Year 8. Date of Birth (Month, Day, Year) July 9,1968 Birthplace (State or Foreign Country) 6. S 7. Age (In grs. last birthday) 5. Social Security Number **Funeral** Days Min. Months Hours 1 XM 2 ☐ F Yrs. Maryland 35 218-02-2023 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "netural", or Itams 23s or 28s-f show any highry or other traumatic event, it is Medical Examination into the notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Directo Dundalk Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 7436 Edsworth Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 █No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: by If Yes, Give Year or Dates: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
11 Years College (1-4or 5+) Trucking Industry Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilma Jean Leake Anthony James Holewinski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ann M. Holewinski (Wife) Dundalk, Maryland 7436 Edsworth Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2004 Towson, Maryland Hilltop Service Corp. 21. Signature of Fundal Service 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.

Duda-Ruck Funeral Home of Dundalk, Inc.

Dundalk Marvland 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 Hours nona /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physicien Physician/Medical IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ (S) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? IRRHOSI 24a. Was an has autopsy perfor 2 🗆 No this certificate 1 Yes 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Denatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital 29a. Certifier t M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier Medical Housestaff RES - 000 2004 lanva 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AT. Menders 600 North Hopkin John 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 1 2004 K Registrar

			For State Registrar	State of Maryland		artment of tificate o		and Me	ntal Hygie	_ 4. U U	4 01222
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last Melvin K. Hess 4a. Facility Name (If not institution, give	street and number)	Le Company	4b. City, Town	or Location o	t de	Date of Death Month	4c. County of E	9 - 11
	Funeral Director		5. Social Security Number 6. Se		ast birthday) Yrs.	If Under 1 Yes Months Day			Date of Birth (Month, Day, Ye) 8 / 1 1 / 1	9	Birthplace (State or Foreign Country) MD
	th the Marylan or 28a-f show e notified at	Irector	10a. State 10b. County MD Anne Ar 10e. Street and Number		,Town or Lo asade				10g.	Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 1 No t Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exam are finial be traffied at anote.	by Funeral Director	8596 Main Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		211 Was Decedent of Yes, specify Co	f Hispanic Orig uban, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		American Indian, White, etc. White
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Maryland	2 should be file and Mental Hy is marked oth sumatic event	Be	17. Father's Name (First, Middle, Last) John Albert Hes 19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Stre	Ada	Mada	irst, Middle, Maid aline S doute Number, Ci	purrie	
Baltimore, N	t. Pages 1 and rtment of Health rtent: If item 27 ijury or other tr		Emilie Hess/Wi 20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State 20b. Place Removal from State	ace of Dispo metery, crem View	sition (Name of natory or other p Cremat	ory 1,	Date /17/0)4 Ba	Location - City	or Town, State
Bal	permit. Departr Importe any inji		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death.	1	69 River the mode of d	iera]	Dr., F	Pasaden espiratory arrest,		11 Home, PA 21122 Approximate Interval Between Onset and Death
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Vital Re	ding Physician: The law n. Atter this certificate has b funeral director, page 2 s	To Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Æl Inpatient 2 □ E	R/Outpatient	3 DOA C			autopsy performed 1 Yes 2 12 heck only one) 5 Residence	? death No 1 □ \	es 280 No
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		2	29b. Signature and title of certifier ### HUL 30. Name and address of person who comes and address of person who comes and address of person who comes are a	pe officer	23a) (Tvpe, i	D	1-3-6 4	2	J C	Date signed (Mo	5 2004 2 106/
	∫Ū Sta Registr		X/A C 2 H 0 q 31. Date filed (Month, Day, Year) JAN 2 1 2004	32. Registrar's Signatu	tal	Dr.	C7/R1	1 150	111.6	M1) 0	2106/

Fless, Helvin

			1 - For State Registrar	State of	Marylar		artment of H		nd Mental F	Reg. No.	ムリリサ	012	23
1	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of Month	Day		3. Time of Do	eath
9-	/Media	al	Karen A 4a. Fecility Name (If not institution,	nn Hanco			4b. City, Town, or	r Location of	Janua		2004 County of Deep	2:15A	IVI
	Examin	er	Shady Grove Adve				Rockv		Doam		ontgome		
	Funeral			S. Sex 7.		last birthday)	ff Under 1 Year Months Days	If Under 2	8. Date of (Month,	Birth Day, Year)		thpface (State or F buntry)	Foreign
	Director		374-66-9301	1□M 2X1F		47 Yrs.	Months Days	Hours	May 1	6, 195	56 Mi	chigan	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d, fnside City	Limits
	Maryl	tor	Maryland Montgo	merv		Roc	kville					1 ☐ Yes 2	X No
	h the	Director	10e. Street and Number	шет у		Roc	10f. Zip Code			10g. Citi	izen of What Co	ountry?	
	23e c	aiD	413 Reading Aven	ue			20850			Unit	ted Sta	tes	
36	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "netural", or tema 23e or 28e-1 show event, the Medical Exertiner rotal be nutilised at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force d 1 Tyes 2 If Yes, Give Year or Date	es? t☑ No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Orig in, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
ŏ	2 hou	ted	15. Decedent's			16a. Dece	dent's Usual Occup	ation	of working	16b. Ki	nd of Business	/Industry	
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	should be filed withir Mental Hygiene. marked other than mattc event, tha M	Cor	17. Father's Name (First, Middle, La	4		Adı	ministrat		's Name (First, Mid			Scientol	ogy
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Maryland	should ind Men marke umatic	ဥ	John Geletka 19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir			ce Chromi ror Rural Route Nui		r Town, State, I	Zip Code)	
	and 2 ealth a n 27 is		Houston E. Hanco	ck/Spouse		413	Reading A	venue	: Rockvil	le, MI	20850		
ore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3	I □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		Place of Disponentery, crer	esition (Name of matory or other place	(8)	Date	20c. Lo	cation - City or	Town, State	
Ĕ	Pages ment of ant: If it		'4 □Donation 5 □Other (Spe			esapeal	ke Cremat	ory 01	1/19/2004	Be1	tsville	e, MD	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>900:e.</u>		21. Signature of Funeral Service Li	Di Me	_	1	040 Rockv	ille 1	Funeral a Pike; Roc	kville	emation e, MD 20	Center 0852	
~	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cau hly one cause on eac	ch line,	th. Do not ent				y arrest,		Approximate Interval Betwee Onset and Dea	
	/Medical Examiner		resulting in death)	Due to (or	as a consec		mel	litu	s			year	ا
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8760,	ate be executed hysician and the burial-transit	icai	resulting in death) Last	Due to (or	r as a conseq	quence of):							
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۵.	Se Go	by	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the u	nderlying cause give	en in Part I.		d tobacco u		the cause of dea	
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Vital	Phyaician: rthis certifica ral director, r	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		ER/Outpatien	ot 3 DOA Othe	DE:	of Death (Check on				
of	Phy er this	n: To	27. Manner of Death	1 □ Inp 28a. Date of (Month,		28b. Time of	IL JU DON	4 14013	sing Home 5 Re 28d. Describ			city)	
io	Attending ir death. actor: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury		k? Yes 2 □ N	lo				
Division	al or Atte s after dei il Diracto ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 200. Flace 0	f Injury - At h g, etc. <i>(Specil</i>	ome, farm, str	eet, factory, office			(Street and Town, State)		ıral Route Numbei	r,
	To the Hospital or Attending Phyaician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying (Check only 2 Medicel E. one)	Physician: To the base caminer: On the base and manne	is of examina	owledge, death ation and/or in	n occurred at the tim vestigation, in my op	ne, date and pinion, death	place, and due to the control occurred at the time	he cause(s) ne, date and	and manner as place, and due	stated. to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date	e signed (Monti	h, Day, Year)	
	.(allierof	18 her	ing n	ns	D3	6970	\	Janu	ans	15,00	04
	IV .		30. Name and address of person w	0	00	n 23a) (Type,	Print)	,	ror (JU	0	, , , ,	1 . 12
100	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	gismal's Signa	ature	dical C	en te	10x. 1	CUCIC	0,112	WD 90	<u> </u>
	Registr		IAN 2	1 2004	7.	20	Read ?						

			1 - State Registrar	State of Mag per phy	yland/Dep Ce	artment of Fertificate of	Health and N Death	nental Hy	glene 2001 Reg. No.	+ 01224
	Dhysiai		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath $1/14/2002$	
	Physici /Medic		Russell Victor I	Hughes				Januar	y 15, 2004	
	Examin	er	4a. Facility Name (If not institution, give s				or Location of Death		4c. County of Dea	
			Hebrew Home of G1 5. Social Security Number 6. Sex		hington In yrs. last birthday		ville □ If Under 24 Hrs.	8. Date of Bir	Montgo	mery thplace (State or Foreign
	Funeral Director			M 2□F 78		Months Days	Hours Min.	(Month, Da	iy, Year) 5, 1925 Mic	ountry)
			Usuel Residence of Decedent					TED. I	J, 1925 1110	nigan
	how		10a. State 10b. County	1	Oc. City, Town or I	ocation				10d. Inside City Limits
	Ba-f-	cto	MD Prince	Georges	Adelpl	ni				XXYes 2 □ No
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	s 23e	rai	10115 Phoebe Lane	2 Was Decadest Fu	or in H C 12		0783	nocity Vos or No	United St	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Exactination in indiffical at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 	er in U.S.	If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		
9-0	2 hou	ted	15. Decedent's Educ		16a. Dec	edent's Usual Occup	pation during most of work	dina.	16b. Kind of Business	/Industry
21	within 7 ene. then *r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		Constant	t i
	filed withir Hygiene. other then ent, the Mi	5	12		Cons	struction	Superint		Construc	L TOII
Maryland	2 should be filed withir and Mental Hygiene. Ie merked other then aumatic event, the Mi	o Be	17. Father's Name (First, Middle, Last) Percival Robert H	lughes					. <i>Maiden Sumame)</i> e Clearihu	e
ary.	should and Men marke umatic	은	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mai	ling Address (Street	and Number or Rui	ral Route Numb	er, City or Town, State,	Zip Code)
	1 and 2 Health a lem 27 ie		Annette M. Maisu/	Daughter	1011	5 Phoebe	Lane, Ade	elphi. N	4D 20783	
J.	of Health item 27		20a. Method of Disposition	C.		position (Name of ematory or other pla		Date	20c. Location - City or	
E	Pages nent of t int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	amoval from State			cory at LI		Baltimore,	MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Juneral Sylvice floor, e	Ollan	. /	22. Name and Addre Simple Tri .040 Rocky	ess of Facility ibute Fune ville Pike	eral and	l Cremation	Center 852
1.	la la la la la la la la la la la la la l	(28a. Pan 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line	ne death. Do not e					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		scleret'z	heart c	Lisease			Onset and Death
70	Examiner				tes mell	itus				
	5 - A	ē	Sequentially list conditions, if any, leading to immediate cause. Enter University in	Due to (or as a	consequence of):					
	acute ind transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Chroni		ctive P	almonar -	Direc	nia	
50,	icate be executed physician and s the burial-transit	ũ	resulting in deathy cast	Due to (or as a	consequence of):		,			
58760,	physic	dicai	d							
. Box	requires that the death certific teen signed by the attending f hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year
P.0	that the dended by the a	Phy	Part II. Dther significant conditions con	tributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use contribute to	o the cause of death?
ords,	w requires (been signe should be	ed by			•			12	Yes 2□No 3□P	robably 4 Unknown
Records,	aw as b	Completed						24a. Was autop perfo	an 24b. Were an prior to death?	utopsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical				26. Place of Deat			
	S 17	P	examiner? 1 ☐ Yes 2 ☑ No H	ospital: 1 Inpatient	2 ER/Outpati	ent 3 DOA	her: Vursing Ho	ome 5 ☐ Resi	dence 6 Other (Spe	icity)
ion of	ding After fune		27. Manner of Death 14☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo	ry at rk?]Yes 2 ☐No	28d. Describe	how injury occurred	
Division	hal or Atto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	street, factory, office		28f. Location (: City or To	Street and Number or R wn, State)	ural Route Number,
1	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examination	icien: To the best of eer: On the basis of e and manner state	xamination and/or	ath occurred at the tr investigation, in my (me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the Comp	ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mont	th, Day, Year)
	1		/ tany 3 W	M	m ' D,	D 22	518		January 15	, 2007
	'U		30. Name and address of person who co		th (Item 23a) (Type	e, Print)	1 111			
		10	31. Date filed (Month, Day, Years as 6		Signature	10 8	K NCKO T CCC	FUT YC	AND 2085	-
	Sta Registi		JAN 2	1 2004	was the of	The state of	2			

			1 - For State Registrar	State	of Mary	yland / Depa <i>Ce</i> a	artmer <i>rtificat</i>					giene Reg. Ne	6 0	04	012	225
	Dhysisi	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Da	ıv	Year	3. Time of I	Death
	Physici /Medio		Thelma G. H	illary							Januar			2004	3:50	p^M
	Examin	er	4a. Facility Name (If not institution,		umber)		1		Location of	of Death		40	. County o	of Death		
			5550 Link Avenu				-	thor		2411			ltimo			
	Funeral Director		212-05-2451	3. Sex 1		n yrs. last birthday) 35 Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Novembe	v. Year	,	Count	ace (State or ry) ryland	
	and *		Usual Residence of Decedent 10a. State 10b. County		10	Dc. City, Town or Lo	ncation							10	d. Inside City	Limite
	Aaryli r sho	ō	Maryland Baltim	0.50	'	Haletho								1	1 ☐ Yes	•
	28a-	Director	10e. Street and Number	OIE .		патесно	10f. Zic	Code				10a Ci	tizen of W	hat Count		
	with Sa or						212								•	
	ns 2%	Funeral	5550 Link Avenu	12. Was Dec	edent Eve	er in U.S. 13.	Was Dece	dent of His	soanic Ori	ain? (Spe	cify Yes or No		ted S			
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be nutified at once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	Armed F	orces? 2 (2000) ive		lf Yes, spe 1 □ Yes	cify Cubar	Specify:	, Puèrto I	Rican, etc.)			, White, e	etc.	
ş	2 hou		15. Decedent's		- 41001	16a. Dece	dent's Usu	al Occupa	ition			16b. K	(ind of Bus			
212-0036	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired)	uring mos	t of workii	ng		partn		Store	2
7	ad wit	201	12					M	arker							
yland	tal Hy	Be	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle,	Maider	Sumame)		
<u>X</u>	Men Men Marke Marke	၉	Henry F. Miche								(unob					
Mar	2 sh and is m	1	19a. Informant's Name/Relationship Sharon Gandee-								Route Number					
	1 and Health		20a. Method of Disposition	Daugnter							ethorpe					
<u></u>	nt of or or or or or or or or or		1 Burial 2 Cremation 3		State	20b. Place of Dispo cemetery, crer			- 1				ocation - C			
Jailimore	artme artme ortani injury	1	* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of F neral 7 rvi€ Lice	• ·		Loudon Pa						04 .	Balti	more	, Mary	land
ם מ	permit Depar impor any ir once.		XIII X So	BROTING	200						Home	imar	o Ma	1 .	. 21 الس	220
4	S. Miles		23a. Part1. Enter the disease, or co shock, or heart failure. List or	molications that	caused the	death. Do not ent	O∠U_W er the mod	a of dying	ns Av , such as	cardiac o	, Balt: r respiratory ar	rest,	e, ma		Approximate	
	Physician	1	Immediate Cause (Final disease or condition			er - metast									Interval Betwo Onset and De	
	/Medical		resulting in death)	d.	19	onsequence of):						_				
	Examiner		Sequentially list conditions	Bre	ast co	anuv										
/	P #	Iner	Sequentially list conditions, if any, leading to immediate	Due to	(or as a co	onsequence of):										
/	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	lor 25 2 00	onsequence of):										
0/00,	cate be executed physician and the burial-transit	alE		00010	(0) 43 4 00	maequence on.										
	ficate p phys is the	edical		d												
200	h certi ending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			Ectopic pr						23d. Date	of delivery	/	
	ed for	sicla	in the past 12 months? 1 ☐ Yes 2 🗷 No		nant at time		Other (sp						Month	п С	Day Ye	ear .
ر ا	at the	Phy	9 Unknown									-				
Ď,	ires the signer	þ	Part II. Other significant conditions	i contributing to d	leath but no	ot resulting in the ur	nderlying c	ause givei	n in Part I.			obaccoι ′es 2		ute to the	cause of dea	
5	v requ	etec									-					
ב ב	has ige 2 s	Completed									24a. Was autop		24b. We	or to compath?	sy findings av pletion of cau	railable use of
מ	n: Th	ပို့	25. Was case referred to medical								1 Yes	2.X.No	1 [Yes 2	No No	
5	sicia certi	o Be	examiner?	Hospital:	Inpatient	2 ER/Outpatien	• • • • • • •	Other			(Check only of	/				
5	g Phy er this eral d	-	27. Manner of Death	28a. Date	of Injury	28b. Time of		Bc. Injury Work?	4 🗀 Nui		ne 5 K Resid 8d. Describe h					
2	ath. r: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	ith, Day Ye	a <i>r)</i> Injury	М		? es 2 □ N	10						
2	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 286. Place	of Injury - ing, etc. (S	At home, farm, stre	et, factory	, office	-	2	8f. Location (S City or Tow	itreet an m. State	d Number	or Rural I	Route Numbe	θΓ,
2	ital o rrs aft rai Di															
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death: within 24 hours after death: To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier Certifying (Check only one)	aminer: On the b	e best of m asis of exa ner stated.	y knowledge, death amination and/or inv	occurred a restigation,	at the time in my opi	e, date and nion, deat	i place, ai h occurre	nd due to the o d at the time, o	ause(s)	and mann place, and	er as stat d due to th	ed. ne cause(s)	
	To t To t	Σ	29b. Signature and title of certifier					. License			2	29d. Dat	e signed (
	1		higscotto				F	0060	010				1 - 19	1-04		
	P		30. Name and address of person wh				,	_								
6	Sta	6	Weiming Seo, 31. Date filed (Month, Day, Year)		466U Registrar's	Wilkens Signature	Avenu	ie, B	altin	nore,	Mary1a	and	21229)		
	Registra	-		2 1 2004 I	Ew/	and H	Line	A D								

				For State Registrar	State of Ma	-	partment o <i>ertificate d</i>	of Health and of Death	Mental Hy	giene	04	01226
				Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death
		Physici /Medic		Benjamin				Hill	Janu	en 12	. 2004	157DM
		Examin		4a. Fecility Name (If not institution, give s	treet and number)	1 / .	4b Gity, Tow	m, or Location of Deat			y of Death	
					leral t	10Spital	Dal	ear If Under 24 Hrs	1.00			
	1	Funeral Director		5. Social Security Number 6. Sex	ÇM 2□F	e (In yrs. last birthda Yrs.	Months Da	ays Hours Min.	(Month, Da	ay, Year)	9. Birthp	place (State or Foreign htry)
				219-01-5234 Usual Residence of Decedent		82 Yrs.			06 2	0 21		SC
		nyland how		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
		e Ma	Director	MD NA		Baltim	ore					1X Yes 2 □ No
		vith th	Dire	10e. Street and Number			10f. Zip Cod			10g. Citizen of	What Cour	ntry?
		s 23s	şrai	2319 Whittier A	Ave 12. Was Decedent 6	Tues in II S 1	2 Mac Deceded	21217	`a#u V \$1		S.A.	no lodico
		ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	Bla	ack, White,	
(5-0036	ursal	Ď	3 Widowed 4 □ Divorced	1 ∑ Xes 2 □ N If Yes, Give Year or Dates:		1 ☐ Yes 3	No Specify:		Speci	fy: B	lack
	5-0	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show the Medical Existing from the notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. De	cedent's Usual Oc	ccupation	rkina	16b. Kind of I	Business/In	dustry
ami	21	athlo ne.	mpie	Elementary/Secondary (0-12)	Coilege (1-4or 5	+)	e. DO NOT use re	one during most of wo atired)	9			
<u>a</u>	121	filed w If Hygiel other ti	Ŝ	8th grade 17. Father's Name (First, Middle, Last)	na	Lo	ngshorm		ne (First, Middle		ocks	
5	anc	Mental Harked of	o Be	Stephen Hill				Irene W		, waiden Suma	1110)	
0	Maryland	12 should be filed with h and Mental Hygiene. 7 is marked other than traumatic event, Lean	F	19a. Informant's Name/Relationship (Ty)	ое, Print)	19b. Ma	ailing Address (Str	reet and Number or Ri		er, City or Town	n, State, Zip	Code)
	Š	2 = 0 -		Bonita V. Hill-I	Daughter	231	9 Whitt	ier Ave,	Balti	more M	d 2	1217
	J.e.			20a. Method of Disposition		20b Place of Dis	sposition (Name o rematory or other	1	Date	20c. Location		
1	altimore	mit. Pages partment of l ordent: If it injury or o		NDBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State			ial Park	1/21/	04 Arb	utus	Md
حسلس		permit. Pages Department of Importent: If i any injury or one		21. Signature of Funeral Service License	(e			dress of Facility H West				1
	8	2023		John B. Ja	Luca	7.	4 300 Wa	abash Ave			Md	21215
				23a. Part1. Enter the disease, or complished, or heart failure. List only on	e cause on each lin	10.	2000000	1 0	or respiratory a	rrest,		Approximate Interval Between Onset and Death
		Physician	F 1/	Immediate Cause (Final disease or condition resulting in death)	Severe	Curona	ery Hr	tery 17	thero	scler	OSIS	Onsor and Doda
		/Medical Examiner		(assume the second	~ I	a consequence of):)		h M	ما م ما	Cac	
			ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):	carcino	ma wit	7) 1114	etasto	1562	- 11
		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Cerebr	ovas cu	Mar 1	Acciden	+			
	o,	an an		resulting in death) Last	Due to (or as	a consequence of):						
	68760,	icate be executed physician and s the burial-transit	edicai		Kena	Foilu	re					
			Mec	IF FEMALE:								
	Вох	eath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome	2 Fetel death	3 Ectopic pregna				ate of delive onth	ory Day Year
	P.O.	res that the de signed by the a l be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time or death	5 ☐ Other (s <i>pecify</i>	<i>"</i>				
		that		Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause	given in Part I.	23e. Did t	tobacco use con	tribute to th	e cause of death?
	rds	quires n sigr uld be	ed by						10	Yes 2 ☐ No	3 Prob	ably 4 Donknown
	00	aw require s been sig 2 should t	oleted						24a. Was		Were auto	psy findings available
	R	The lay	dmo						auto oento	psy ormed? 2 ☐ No	death?	npletion of cause of 2 No
	ital	ysicien: The is certificate hi director, page	Be C	25. Was case referred to medical examiner?			1	26. Place of Dea	ath (Check only o			
	Ž	Physic this ce al dire	၉	1 □ Yes 2 ₽ Mo	ospital: 1 Inpatie		ient 3L DOA		lome 5□Resi			<i>'</i>)
	'n	ding P h. After I funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injun	y 1	njury at Work?	28d. Describe	how injury occu	rred	
	isic	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Init	ıry - At home, farm,		1 ☐ Yes 2 ☐ No	28f Location (Street and Num	her or Rura	I Route Number,
	Division of Vital Records,	l or Atten after deat Diractor: I in by the	Certification:	4 Homicide determined	building, etc	c. (Specify)	street, ractory, on		City or To	wn, State)	Der OFFILIA	rrodie rumber,
4	1	To the Hospitel or Attending Physicien: The law requires that the death certi within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ledical C	29a. Certifier 1 Certifying Phys	ician: To the best of	of my knowledge, de	eath occurred at the	e time, date and place ny opinion, death occu	, and due to the	cause(s) and m	anner as st	ated.
	1	the H hin 24 the F nplete	Medi	one)	and manner sta	ted.						
	1	5 twit	~	29b. Signature and title of certifier	0	11 5	29c. Lic	pense number		29d. Date signe		vay, rear)
		6		20 Name and distributed	majated same of t	M L	87	778		11120	1003	
)		30. Name and address of person who co Chike Gregori	mpleted cause of de	DUKA	HO 7	o Mary	land	Gener	a	Hospital
		Sta Registr		31. Date filed (Month, Day, Yeal)	32. Registra	r's Signature	Low	,				,

		•	For State Registrar	State of Maryla	•	artment of H			giene 20 (04 01227
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Frances	F. /	Harr			2. Date of Dea Month	774 20	
	Examin	er	4a. Facility Name (If not institution, give: LOWEW NUS 5. Social Security Number 6. Sec	ing Home	s. last birthday)	4b. City, Town, or	If Under 24 Hrs	red	4c. County of	Birthplace (State or Foreign
	Funeral Director		113-28-3857 Usual Residence of Decedent]M 2 X F	99 Yrs.	Months Days	Hours Min	8. Date of Birth Month, Pay 7/26/19	904"	NY 10d. Inside City Limits
	the Maryla 28e-f shov	Director	MD HOWA		•	UMBIA	<u></u>	1	log. Citizen of Wha	1 □ Yes 2 No
	s 23a or		6336 CEDAR LANE	12. Was Decedent Ever in	11.5 12.		21044			U.S.A.
920	be filed within 72 hours after death with the Maryland ital Hygiene d other than "naturel", or Items 23a or 28e-f show event, I've Medical Exatration must be motified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	to Rican, etc.)		White, etc. WHITE
21215-0036	within 72 ho iene. Ithan "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	orking	16b. Kind of Busin	
Maryland 2	should be filed and Mental Hygis marked other umatic event, it	To Be C	17. Father's Name (First, Middle, Last) JACOB		PAL		18. Mother's Na ESTH	me (First, Middle, ER	Maiden Sumame)	COHEN
	nd 2 sho allth and 27 is m r traum		19a. Informant's Name/Relationship (Ty ALAN HARRIS / SON	· · · · · · · · · · · · · · · · · · ·	1204	ng Address (Street		- COLUMI	BIA, MD 2	1044
Baltimore,	permil. Pages 1 a Department of Hes importent: If item any injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X F 4 ☐ Dination 5 ☐ Other (Specify) 21. Striating of Funeral Section in	Removal from State	Cemetery, creat	esition (Name of matory or other place EL CEMETE	RY 1/19	/2004		, NEW YORK
Ba	Depa impo impo any is		23a. Part 1. Enter the disease, or copyol shock, or heart failure. List only or	gar			STERSTOW	N ROAD -	PIKESVIL	OS., INC. LE, MD 21208
-	Pnysician /Medical Examiner		shock, or heart failure. List offly or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a Due to (or as a conse	Bile equence of):	ateral	Press.	monia t xau	lure	Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.	aquerio			0		
P.O. Box 6	that the death certifics ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
	sign sign d be	þ	Part II. Other significent conditions con	ntributing to death but not re Taundi Julan	-			23e. Did to	1.4	te to the cause of death? Probably 4 Unknown
II Reco	The law ate has b page 2 si	Completed		sular.	mal	ignar	y	24a. Was a autops perform	med? deal	e autopsy findings available to completion of cause of the cause of th
Division of Vital Records,	Attending Physicien: The death. ector: After this certificate by the funeral director. pag	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 2 [28a. Date of Injury (Month, Day Yeer)	ER/Outpatier 28b. Time o Injury	f 28c. Injun World	er: 4 Nursing I	ath (Check only on Home 5 Reside 28d. Describe ho		Specify)
Divisi	2 2 2 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
2/	To the Hospitel of within 24 hours all To the Funerel D completely filled it	edicai	(Check only 2 Medicel Exemi	sicien: To the best of my ki ner: On the basis of examin and manner stated.	nation and/or in	vestigation, in my o	pinion, death occ	urred at the time, d	ate and place, and	due to the cause(s)
•	J September 1	Σ	29b. Signature and alle of certifier	i, m		29c. Licens	0 8 70		9d. Date signed (N. Danuar)	MD 21029
()	5		30. Name and address of person who co	MD 500		Print) B	ell In	. Clar	lisible.	MD 21029
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 1 2004	32. Registrar's Sig	aturo Con					

	State of Maryland / Department of Health and Mental Hygiene Amend Item 4a per Dr., G827, 01/21/04dhb Certificate of Death	1220
Physician (Madisal	1. Decedent's Neme (First, Middle, Last) Newton Guilford Hayden, Sr. 2. Date of Death Month Day Year	Fime of Death
/Medical Examiner	As Facility Name (forth institution of a street of a street of	:25AM
Funeral Director	216-20-6736 X M 2 F 79 Yrs. Months Days Hours Min. Oct. 31, 1924 Maryla	State or Foreign nd
the Meryland 28a-f show nortified at	Marxiland M/A Doltimore	side City Limits □ Yes 2√∑ No
D uter death with the Me or tems 23e or 238-1 s niner must be noriffed funeral Director	10e. Street end Number 1008 Rockhill Ave. 10f. Zip Code 21229 10g. Citizen of What Country? U. S. A.	Λ
020 urs	The state of the	ian,
— c · a =	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Electronic Technician 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Technician Electronics	
yland ould be file Mentel Hy Mentel Hy arked othe aftic event.	17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame)	
Baltimore, Maryland 212 permit. Peges 1 end 2 should be filed within Department of Health end Mentel Hyglene. Important: if Item 27 is marked other than any Injury or other traumatic event, the M ance. To Be Comp	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Newton G. Hayden, Jr. / son 522 Benforest Dr. Severna Park, MD. 2114 20a. Method of Disposition 1	46
Baltil permit. F Depertm Importen any Injur	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Ambrose Funeral Home, Inc.	1227
Phýsician /Medical Examiner	23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such established a such established and extended a such established.	oximate al Between t and Death
K 68760, trifficete be executed ng physicien end e set the buriel-transit	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Content Con	mins mins
I Records, P.O. Box E The law requires that the death certifi ste has been signed by the ettending page 2 should be deteched for use as Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronory artery disease 11 Yes 2 No 3 Probably	nuee of death?
ital Records, an: The law requires the lifficate has been signe for, page 2 should be completed by	24a. Was an autopsy performed? 24b. Were autompletic completic of death?	opsy findings prior to n of cause
of Vital I Physician: The this certificate rel director, page	25. Was case referred to medical example? 1	
Division of Vita Division of Vita tal or Attending Physician: rs etter death. al Director: After this certificial in by the funeral director, Certification: To Be (27. Menner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	
기술 병원으로 합니	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only 19 Medical Symptosis of Market and Market Symptosis of Market and Market Symptosis of Market Market Symptosis of Market Market Symptosis of Market Market Symptosis of Market	Number,
To the Hospital of within 24 hours et puneral Denne Funeral Denne Puneral Medical Cel	one) and manner stated.	
	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) THOMAS T. ENELOW, M.D.	704
State Registrar	ST. AGNES NEACTNEARE 900 CATON AVE BALTIMORE, MAZIZZ 31. Date filed (Month, Day, Yeer) JAN 2 1 2004 2004	9

DHMH 16 Rev 6/95

				State of Maryland /			-	_	
		•	For State Registrar		Certificate			1. No. 2004	01229
	Physici		Decedent's Name (First, Middle, Last)	DOROTHY	JA	MES	2. Date of Death Month JANUARY	Day Year 15, 200	3. Time of Death 7-29 A-M
	/Medio Examin		4a. Facility Name (If not institution, give st	reet and number)		vn, or Location of Death	/	4c. County of Death	
			NORTH WEST			lallstown Gear If Under 24 Hrs.		Baltir	
	Funeral Director		212-70-3901	7. Age (In yrs. last b	oirthday) If Under 1 Y Yrs. Months D	ays Hours Min.	8. Date of Birth (Month, Day, Y June 6,		place (State or Foreign intry) aryland
	rland ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	e Man 3a-f sh tiffed	Director	MD Baltimon	:e	Randallst				1 ☐ Yes 2 ☑ No
	with the	Dire	10e. Street and Number 8418 Lucerne Ro	ad	10f. Zip Co	de 133	100	g. Citizen of What Col	untry?
	ns 23	era		2. Was Decedent Ever in U.S.		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
936	urs after o	by Funeral	1 ★ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates:	If Yes, specify 1 ☐ Yes 2 ☑		Hican, etc.)	Black, White	white
21215-0036	be filed within 72 hours after death with the Maryland stal Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Mydical Examiner court be motified at	Completed by	15. Decedent's Educ (Specify only highest grade	ation 16 completed) College (1-4or 5+)	ia. Decedent's Usual O (Give kind of work of life. DO NOT use r	occupation fone during most of work etired)	king 16	6b. Kind of Business/I	ndustry
	filed wit Hygiene sther tha	Com	-0-		Disabled				
Ind	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last)				e <i>(First, Middle, Ma</i> nerine Dot		known
yla	should be and Mental s marked o umatic eve	ဥ	Kenneth Jam 19a. Informant's Name/Relationship (Type		Ob Mailing Address (S	treet and Number or Rui			
, Maryland	and 2 st ealth and n 27 Is r			regiver 9	0 Painters	Mill Road	Owings 1	Mills, MD	21117
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once</u> .		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)		of Disposition (Name of tery, crematory or other	on Ser. 1/1		oc. Location - City or T Hampstead	
Ħ	artme ortan injur		21. Signature of Funeral Service License					terstown R	
ä	permit. Departr Importa any inje	1 19	Stephen n	1 Jenkins	ELINE F	UNERAL HOME	Reister	stown, MD	21136
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. Do					Approximate Interval Between Onset and Death
	Physician /Medical	S 13	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	SEPSIS				DAYS
	Examiner		Sequentially list conditions, b.	PAN	CYTOPE	ENIA			MONTHS
1	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	e oi)i				
,092	tificate be executed ig physician and as the burial-transit	cal Exa	resulting in death) Last	Due to (or as a consequence	e of):				
687	ificate g phys		_ d						
P.O. Box	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregr 5 Other (special			23d. Date of deli	very Day Year
	that ned by deta		Part II. Other significant conditions con	ributing to death but not resulting	in the underlying caus	se given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	en sig	ed b	DIABETES	MELLITO	75	-	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
ecc	law re nas be e 2 sho	Completed by				-	24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
=		S					performe 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2 No
Vita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Othon	th (Check only one)		-1
o	Phy rthis rald	٠ <u>۲</u>	1 ☐ Yes 2 No	28a. Date of Injury 28b	Outpatient 3 DOA D. Time of 28c.	Injury at	ome 5 Residen 28d. Describe how	ce 6 Other (Spec	ify)
ion	Attending r death. ector: After y the fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, o	ffice	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	Hospit. 24 hours Funera	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowled er: On the basis of examination a and manner stated.	lge, death occurred at t and/or investigation, in	he time, date and place, my opinion, death occur	and due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and tive of certifier		29c. L	icense number	290	d. Date signed (Month	. Day, Year)
	F > F 0		1 Vasan	thalcuma		42510		JAN, 15	14, 2004
	2		30. Name and address of person who co		a) (Type, Print)	icense number 12510 042510	D, MD	21228	
	Sta		31. Date filed (Month, Day Year)	32. Registrar's Signature	is how	still .			

AKG	01,5		State Unpend Item#23a-	State of Marylan b,27,28a-f,PEr M	d / Depa E,G829	artment	of H	ealth ai Death	nd M		ene 2	004	Contract of the contract of th	230
			Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of	Death
	Physici		Shellean	-7	one.	5				Month January	Day 17,	2004	9:02	A^{M}
	/Medic Examin		4a. Fecility Name (If not institution, give s		0,, 0.		Fown, or	Location of	Death			inty of Death		
4	Examili	EI	John Hopkins Hospi			Balt	imor	æ				N	B	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24	4 Hrs.	8. Date of Birth	Vear)	9. Birth	place (State o	r Foreign
	Director		218-96-4429	M 20 F 23	Yrs.	Months	Days	Hours	MIII.	8. Date of Birth (Month, Day,	7980)	MO	
	D.		Usual Residence of Decedent									1	40d Inside O	
	inylar show		10a. State 10b. County		y, Town or Lo								10d. Inside Ci	-
	9 Ma	cto	N/A		Bult									
	hours after death with the Maryland turel', or liems 23a or 28e-f show at Examinst must be multied at	by Funeral Director	10e. Street and Number	0 4		10f. Zip				10	-	of What Cou	intry?	
	23a	ra	119 N. Highland	Avenue				455				154		
	tems	nu	11. Marital Status	 Was Decedent Ever in U. Armed Forces? 	S. 13.	Was Deced If Yes, spec	ent of His	spanic Origi n, Mexican,	n? (Spe Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White		
36	s afte	Ϋ́F	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 🗆 Yes 2	2 No	Specify:			Spe	cify: 3	lack	
215-0036	hour turel		15. Decedent's Educ		16a Dece	dent's Usua	I Occupa	ition		1	6b. Kind o	f Business/I	ndustry	
15	in 72 in ma redic	ojet	(Specify only highest grade	completed)	(Give	kind of wor. DO NOT us	k done d	uring most of	of workin	ng l			,	
212	the iene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		lerk	-				1	Ew F	Then	
	Hygi other	O	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle, M	aiden Sun	name)		
au	id be ental ked d	To Be	Johnny Jack	son Sr.				F	-van	rces J	ones			
Maryland	shound M mar	-	19a. Informant's me/Relationship (Ty)	oe, Print)	19b. Maili	ng Address	(Street a	nd Number		Route Number,			p Code)	
Ĭ	nd 2 lith a 27 is		Theresa Jones/	Sister	119	N. H	Ahlo	md A	Ive	we B	Utim	one M	5150	RS
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Examinal must be indified at		20a. Method of Disposition		lace of Dispo	matory or of	ther place	a)	,			on - City or T		
Ë	Pages ent of nt: If i		1 A Burial 2 ☐ Cremation 3 ☐ R 3 ☐ Other (Specify)		Wt-20	2000 C	د سع	las I	1/24	104	ans	Jours &	MA	ワ
Baltimore	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funeral Service Lanse	90	2	2. Name and	d Addres	s of Facility	*	Fineral Batt. M	1 (0.		PA	
ä	Depa Impo eny ii	1 1	> X/a/-			1784	to t), Clo	Je	Balt. M	0 2	120/	120	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Pneumonia compliance of the cause on each fine. Pneumonia compliance of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complications of the complex of the c	icating uence of): E epidur	anoxic	-isch	ennic en			,		Approximate Interval Bet Onset and I	ween
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s, P	gned gned	by Pi	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying ca	ause give	n in Part I.					the cause of d	
ord	v require been si should b	ted								1 Tes	2 2 No		bably 4 🗆 L	ANNOWN
Vital Records,	The law ate has be page 2 sh	Completed								24a. Was an autopsy perform Yes 2	- 1	b. Were aut prior to co death? 1234'es	opsy findings a completion of ca 2 No	available ause of
/ita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	1			04		of Death	(Check only one)			
of \	shysik this c	2	XXes 2 No		₹ R/Outpatier			4 LI Nuis		ne 5 🗆 Resider			ify)	
u c		ü.	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 7/9/02 7/9/02	28b. Time o Injury		Bc. Injury Work			8d. Describe hov				
Sio	Attending r death. ector: After oy the fune	cati	2 Accident investigation			P M	1 🗆 Y	∕es XX N	_	nesthetic				
Division	el or Att s after de il Direct id in by t	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At he building, etc. (Specify hospital		reet, factory	, office			Bf. Location (Stre City or Town, D General	State)			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		sician: To the best of my knoner: On the basis of examina and manner stated.)
	To th within To th compl	Me	29b. Signature and title of certifier			29c	. License	number		29	d. Date sig	gned (Month	, Day, Year)	
) Una	1. 1/		0.	.C.M	.E.			Janı	ary 1	8, 200	4
			30. Name and address of person who co	impleted cause of death (Item	n 23a) (Type,								<u> </u>	
			JACK W. Tit	us mid			Peni	n Stre	eet,	Baltimo	re, l	Maryla	nd 212	01
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	yare	-						-		-
	Registr	ar	IAN 2 1 2004	mene	A	south								

		For State Registrar		Department of Health and Note of Death	/lental Hygien Reg. N	2000 0120
Physicia		1. Decedent's Name (First, Middle, Last)	1/4		2. Date of Death Month Da	3. Time of Death 16 2004 11 15 A M
/Medic Examin Funeral Director		4a. Facility Name (If not institution, give	street and number) 7. Age (In yrs. last bir	4b. City, Town, or Location of Death Baltery Continued thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year	9. Birthplace (State or Foreign
5-0036 72 hours after death with the Maryland natural, or items 23e or 28a-1 show lical Erana retrinat be cotified at	Director	10a. State 10b. County Mayland 10e. Street and Number	10c. City, Tow	n or Location TIMER 10f. Zip Code	10g C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No itizen of What Country?
ath with 1 123e or 2	ral Dir	3722 Crestfie		21215		USA
1036 Ours after death with the Marylan raf', or tems 23e or 28a-f show Example profitted at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Orivorced	12. Was Decedent Ever-in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cubab, Mexican, Puerto 1 Yes 2 No Specify:	ecity Yes of No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Z1Z1 d within giene. r than "	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring	rivate Duty
be file tal Hy d oth	To Be C	17. Father's Name (First, Middle, Last) GROGGE ANTH	1	Reserve		
C 2 14 F		19a. Informant's Mere/Relationship (Ty RCH & Alexandre 20a. Method of Disposition	20b. Place o	Mailing Address (Street and Number or Rule) 1 Disposition (Narge of ry, crematory or other place)	Baltiman	or Town, State, Zip Code) 21216 Mayara Cocation - City or Town, State
Baltimore, permit. Pages 1 a Department of Hez Important: if item any injury or othe		1 ☐ Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	M+ 2	22. Name and Address of Facility Pa		
Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	not enter the mode of dying, such as cardiac cranial Bleed		Approximate Interval Between Onset and Death 24hours
Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	typertension of:		Years
The Cords, P.O. BOX 08/00, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	l3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
COLDS, P.	by	Part II. Other significant conditions co	ntributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, 'e)
UN To the Hospital or a within 24 hours after To the Funeral Dirac completely filled in b	Medical			e, death occurred at the time, date and place, d/or investigation, in my opinion, death occur		
To th within To th compl	Me	29b. Signature and title of certifier	0	29c. License number		ate signed (Month, Day, Year)
m		30. Name and address of person who or			Jar	nuary 16, 2004 nove MD 21229
Sta Registr	10	31. Date filed (Month, Day, Year).	32. Registrar Bighature	D 900 Caton AV	e baltu	MOVE MI) 21229

Gwen Jenkins

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PICKETT JOHNSON 0840 ANUARY 20 12004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Locetion of Death 4c. County of Deeth Examiner MERCY BALTIMORE NIA 8. Date of Birth (Month, Day, Year) 04-23-19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 409.30.7766 Usuel Residence of Decedent 1 □ M 2 KF 83 Yrs. Director e filed within 72 hours after daath with the Maryland al Hygiene.
other than "naturel", or items 23a or 25e-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r frems 23a or 28e-f sho finer must be notified at 1 X Yes 2 □ No Funeral Director BALTIMORE MD N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 WOODINGTON 21229 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE 10 TH GRADE DUIY NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Haalth and Mental H ELBERT MCCLAIN IDA 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) JOHNSON MHOD 905 N. WOOD NGTON RD. FAITO. NO 21229
tion (Name of Date 20c. Location - City or Town, State Baltimore, other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Dapartment of Important: If it eny injury or co 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 01-27-04 OWINGS MILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service 4 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATE PIKE, BALTO, MO 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final diseese or condition resulting in death) /Medical Lunce Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for usa as the burial-transit Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated executions) Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that ma dat within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be datached for the funeral file. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yos 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS Pice 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) 3 20/2004 40854 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldimore 9 301 ST PAUL PL Riseberg 31. Dete filed (Month State Registrar

TOHINSON

				State of Maryland / Department of Health and Mental Hygiene 2004 012	33
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		/Medic Examir Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County o	-
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	0		×	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16, 20	DY
	£	5		30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) MANUEL M. (AZADA, MD.) S Law Street Abeyday,	101
		Sta Registi	_	31. Date filed (Month, Day Jan 2 1 2004 Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Vear Jin Kim January 19 3:45 P M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mellenium Nursing & Rehabilitation Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 1 F 530-64-6004 Director Korea Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 200No Director Maryland Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8398 Governors Run 21043 or items 23a United States death Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Innportant: if frem 27 is marked other than "natural", or item any injury or other traumatic event, the Mudical Ferr Black, White, etc. 1 ☐ Yes 2√2No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Asian 3

Widowed 4 □ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bang Jang Sung Kim Hae Soon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Kim - Daughter 334 Governors Run Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Balt. Wash. Crematory 1/22/04 Laurel, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home At MMP., Inc.
7250 Washington Blvd. Elkridge, Maryland 21. Signature of Funeral Service Licensee M. Pah 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DRGANIC BRAIN SYNDROME /Medical Due to (or as a consequence of): Examiner HYDRO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed BLEEDING INTRACRANIAL ANEURYSM Due to (or as a consequence of): attending physician for use as the buria Box 68760 Be Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached t P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DYSCHAGIA 1 ☐ Yes 2-TINO 3 Probably 4 Unknown PRESSURE ULTERS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate SEPSIS 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 | Inpatient 1 Yes 2 No Other: ursing Home 5 Residence 6 Other (Specify) ğ Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation s after decreal Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funeral Di completely filled in certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier The second of the best of the 29b. Signature and tiffe 29c. License number 29d. Date signed (Month, Day, Year) 1104 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Chorce 31. Date filed (Month, Day, Year) 3. Registrar's Signature State JAN 2 1 2004 Registrar

			For State Registrar	State of Marylar	nd / Dep <i>Ce</i>	artment of I <i>rtificate of</i>	lealth and I <i>Death</i>		iene 200	4 01235
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	d tra		Elaine L. King (V	Vife)	258	Riversid	e Road, E	dgewater	, MD 21037	7
ore	of He of He if item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	1 ,	Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City o	r Town, State
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Baltimore,	permit. Pages 1 and Department of Heal Important; if item 2 eny injury or other once.		21. Signature of Eunesal Service Licen	see MI	2	2. Name and Addre Hardest 12 Ridge	v Funeral	Home, P	.A. olis, MD 2	21401
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Division of Vital Records,	To the Hospital or Attending Physician: whihin 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, factory, office		28f. Location (St. City or Town	reet and Number or Fi n, State)	lural Route Number,
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	To the Hospital within 24 hours or To the Funeral completely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	pinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	0		29c. Licens		2	9d. Date signed (Mon	
,			Kallenia	Chua, Mr		P	17692		Jan. 1(0,2004
	6		30. Name and address of person who	775		Print)	- 01	0 11.	ore, MD	
9	Sta	te	31. Date filed (Month, Day, Year)	32. Hegistrar's Signa		green	e st.	MALTINCI	DAG! ANID	21201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stete Registrer Amend Item #26 per phy G827 1/21/Quertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 46272006 KIRBY としいてみるじてけ 11=45A M JAN 16 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BEZA12 HALLONS 1312 SCOTTSDALE OPIJE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 82 220-09-5832 Director 1921 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Expresses must be routilled at Director Keedysville 1 ☐ Yes 2 XNo Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Rockingham Drive 21756 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White δ 3 X Widowed 4 ☐ Divorced ind, Gertrud Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12th Grade Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be to and Mental I Charles W. Griffith Gertrude Elizabeth Willoughby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ages 1 and 2 It of Health a If item 27 ls 7 Rockingham Drive, Keedysville, MD Ms. Cindi Kelley (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State pe mit. Pages 1
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en, injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem'l Park 1/19/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HASUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No CONYEDTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? STAGE 1□ Yes 2⊠ No 220 RENA 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 ZNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21800 JAN16, 2004 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Timo Nion MD 21093 ·S. PRABHU MA 2336 31. Date filed (Month, Day, Year) 32. Registratignature State Registrar

			1 - For State Registrar	State of I	Marylar		artmen rtificate			and M	lental Hygi	ene 2	004	The state of the s	23
	Physici	an	Decedent's Name (First, Middle, Last		, ,						2. Date of Death Month	Day	Year		e of Death
	/Media	cal	Mary Josephine 4a. Facility Name (If not institution, give				4h City	Town or	Location of	of Death	January	1	004 ity of Death	4:00) P M
	Examir	ier	1233 Bonaire Roa		0.,				Hill				arkon		
	Funeral		Social Security Number 6. Se	x 7.		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth		9. Birth	place (Stat	te or Foreign
	Director		212-30-0932]M 2[X[F	64	Yrs.	WOTHING	54,5	1100.0		8. Date of Birth (Month, Day, June 9,	1939	Penr	isýlva	ınia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation			-				10d. Inside	City Limits
	Many Sefsh	tor	Maryland Harford			For	est H.	ill						1 □ Y	es 2∏No
	or 28	Olrec	10e. Street and Number		.1		10f. Zip	Code			1	g. Citizen o		intry?	
	s 23a	ral	1233 Bonaire Roa			10				1050			.S.A.		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mentall Hygiene. Department of Heatil and Mentall Hygiene. The Maryland of Heatile and Mentall Hygiene. The Madical Evantment of the theory any right of the results of the results any right of other traumatic event, the Medical Evantmen must be notified at an once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🕱 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	s?		Was Deced fYes, spec 1 ☐ Yes 2			gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	ВІ	ack, White		4
Maryland 21215-0036	hours ural',	d by	3 Widowed 4 Divorced	Year or Date	s:							Spec		hite	
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pu	be filed ital Hygi od other event, L	Bec	17. Father's Name (First, Middle, Last)								(First, Middle, M	aiden Suma	ame)		
yla	should to and Ment marked umatic o	T _O	Irvin King							seph		shey			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty Ronnie Feldmann		-0 H \						i Route Number, est Hill			o Code)	
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. F	Place of Dispo						•	ocation - City or Town, State		
E	Pages nent of I int: If it		1 🕅 Burial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify)	lemoval from Sta		reland				1/20	/2004 B	altim	ore.	Marul	and
	permit. Departminity in ports any inju		21. Signature of Funeral Service Licens	88					s of Facilit	Schi	munek Fu	neral	Home	S	
	20539		Janes 1/4	7,0							altimore	-	21236		
	nysician		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List opty one cause on each line. Immediate Cause (Final disease or condition A cute full man and fallows.											3etween	
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	quence of):		0						400	2
		er	Immediate Cause (Final disease or condition resulting in death) A cute full monay Edema Due to (or as a consequence of): Acute Respiratory Faulure Due to (or as a consequence of):											2 de	lays
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):												
68760,	icate be physicia s the bur														
Box (n certif anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			1					23d. D	ate of deliv	ery	
P.O. B	that the death certific ed by the attending p detached for use as i	Physician/Medical	in the past 12 months? 1 ☐ Yes ZENo 9 ☐ Unknown	1⊟Live birth 4⊟Pregnan 9⊟Unknowr	t at time of d		Ectopic pre Other (spe					М	lonth	Day	Year
ري. ص	uires that signed b d be deta	by Pl	Part II. Other significant conditions con			sulting in the u	nderlying ca	use give	n in Part I.		23e. Did toba	icco use cor	ntribute to t	he cause o	of death?
ğ	w require been sig should b			Hypox	.emis							2 □ No	3 Pro	pably 4	Unknown
Records,	has be	Completed		Chrone	2800	struc	nine,	Pulr	ronay	Dise:	24a. Was an autopsy		prior to co	opsy finding	gs available if cause of
<u> </u>	: The cate h	Con		Rheum	atora	1 arth	nds				perform 1 Tes 2		death?	2 □ No	
Z Z	Attending Physician: The rideath. sector: After this certificate hiby the funeral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		leno		Othe			(Check only one				
ō	ਵ ≑ ਛ	-	27. Manner of Death	28a. Date of I		ER/Outpatien 28b. Time of		Bc. Injury Work	4 🗀 1401		ne 5 🔀 Residen 28d. Describe hov			y)	
loi	Attending at death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident Investigation	(Month,	Day Year)	Injury	М		es 2 🗆 t	10					
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier Coneck only one) Certifying Physical Examination	ner: On the basis	s of examina	owledge, death	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the cau and at the time, dat	ise(s) and m e and place	nanner as s , and due t	tated.	9(s)
	ro the vithin ; or the omple	Med	29b. Signature and title of certifier	and manner	stated.		29c.	License				d. Date signi			
1	/ /		Breg M.	1RZ4 /	7. B1	416 M		DY	+311	5		1-1	9-09	1	
	5	18	30. Name and address of person who co	mpleted cause of	of death (Item	n 23a) (Type.		-	_		8 -				
			615, 5- Unis				N	1D	, 2	10)	8 ,				
17.	Sta Registr		31. Date filed (Month, Day, Year)	2 1 2004	strar's Siona	ature	M A	book							

			1 = For State Registrar Amend Item #20	State of Maryland Ob per fh G827 1	d / Depa /21/ © e/	artment of Has rtificate of I	lealth and I Death		ene 20 (14 01238
	Physici /Medic		1. Decedent's Name (First, Middle, Last) EL129551 -	JUAH KOFF	A-N	EPAY		2. Date of Death Month	Day Y.	
å	Examin Funeral	er	4a. Facility Namé (If not institution, give st 3735 Court R. T. Le 5. Social Security Number 6. Sex	1 gh DR	ast birthday)	4b City/Town, of	Location of Death	8. Date of Birth (Month, Day, 07 29		Death On ORG Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	^M ※ 65	Yrs.			07 29	38 _I	iberia
	Marylar e-f show	ctor	MD Baltimon		ndall	stown				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Director	10e. Street and Number 3735 Courtleight	t Drive		10f. Zip Code	1133	10	g. Citizen of Wha	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If I tam 27 is marked other than "natural", or itams 23a or 28e-f show or other freumatic event, the Medical Examiner must be notified at	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Black
aryland 21215-0036	thin 72 ho e. en "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	rking	6b. Kind of Busin	ess/industry
d 21	filed wit Hygien other the	Be Con	5th grade 17. Father's Name (First, Middle, Last)	na	Busi	ness Wo		S ne (First, Middle, M	elf-Emp aiden Sumame)	oloyed
ylan	should be and Mental marked o	To B	Koffa Jonah				Mary W			
≥	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type Patrick Nepay-Sc		1				•	te, Zip Code) 21133 cown, Md
timore,	permit. Pages 1 ar Department of Hea Important: If Itam any injury or otha once.		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pi	ace of Dispo emetery, crer	sition (Name of matory or other plac	1/24/	Date 2 04	0c. Location - Cit	
Baltii	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License		Ma	Name and Address	ss of Facility West	Baltim		21215
	Physician /Medical		23a. Part1./Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease of condition resulting in death)	eations that caused the death e cause on each line.		^	,	or respiratory arres		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):					/
oʻ	cate be executed physician and the burial-transit	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
8760	cate be physiciá the bu	dical	€ d.							
O. Box 6	that the death certificate be executed ad by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Bc. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ds, P.	uires that the signed by Id be detacted		Part II. Other significant conditions cont	tributing to death but not result	ilting in the u	nderlying cause give	en in Part I.	23e. Did toba		te to the cause of death? Probably 4 [Unknown]
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Division of	ding Ph h. After th funeral	I	27. Manny of Death 1 Vilatural 5 Pending 2 Accident investigation	1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	THE RESERVE AND ADDRESS.	ome 5 Mesider 28d. Describe hov		Бресіту)
Divis	al or Attend after death Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
2/	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physical Continue one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	n occurred at the tin vestigation, in my of	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manne te and place, and	r as stated. due to the cause(s)
)	within 2 within 2 complet	Me	29b. Signature and little of certifier	110- TILLY	$\overline{}$	29c. Licenso			d. Date signed (NANUARY)	
	ψ		30. Name and address of person who cor	mpleted cause of death (Item	23а) (Туре,	Print)	and-EL	L' A ==/	Fuha	12,2004 Rylang 20042
	Sta	ite	31. Date filed (Month, Day, Year)	1 22 Begistrar Signat	ure	Inosti	, o	-/(011/	Miller	-1.41.9

		1	For Stata Registrer	State of Maryland		artment of I			jiene leg. No. 200	4 01239
,	Physicia /Medic Examin	an al -	1. Decedent's Name (First, Middle, La	KINGSBURY		4b. City, Town, o	or Location of Death	2. Date of Dea Month	th Day Ye	4 6.15 "
	Funeral Director		Nor Mues 7 5. Social Security Number 6. S 217-66-6926 Usual Residence of Decedent	HOSPITAL Sex 7. Age (In yrs. In	ast birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreign Country)
	the Maryland 28e-f show coffined at	Director	10a. State 10b. County 10e. Street and Number	10c. City BA	, Town or Lo	Cation			10g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with fine Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time X71s marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, It a Medical Examinar must be notified at once.	rai	2/57 LORRA: 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	212	O / Hispanic Origin? (S an, Mexican, Puert		USA 14. Race - A	American Indian, White, etc.
21215-0036	in /2 hours at n "natural", or Medical Exem	Completed by F	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece	1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor	king	Specify:	BIACK ess/Industry
land 212	ild be tiled with lental Hygiene. 'ked other that iic event, the h	To Be Com	Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last CAMES L. Fr	College (1.4or 5+)	Com	puter	Progra 18. Mother's Nan Edna.	mer ne (First, Middle,	Composition (Composition of Composition ter	
Ž	1 and 2 should Health and Men tem 27 Is marke other traumatic	F	19a. Informant's Name/Relationship Adviene U. G 20a. Method of Disposition	Type, Print) ee/DoughTer 200, Pl	/000	3 Wood	tey W	Pal Route Number	r, City or Town, Sta	00 21117
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	cate be executed bhysician and the burial-transit	dicai Examiner	Cause Cleases of liquid that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):	ATH	,			
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Division	al or Attend s after death il Director: ,	Certification:	2 Accident investigation 3 Suicide 6 Could not 4 Homicide determined	De Diese of laius. At he	ome, farm, str		168 2010	28f. Location (S City or Tow	treet and Number o n, State)	r Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one) 1 Certifying P 2 Medical Example 29b. Signature and title of certifier	hysician: To the best of my knorminer: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the tivestigation, in my	opinion, death occu	rred at the time, d	ause(s) and manne late and place, and	due to the cause(s)
	. 1		30. Name and address of person who		M - O 1 23a) (Type.	Print) Jo Gal	WOEL P	MEIT	inchang 16	1th, 2014.
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· var	Physic /Med Exami	ical	Decedent's Name (First, Middle, Las MI KHAIL KLO 4a Facility Name (If not institution, give	POUKH			4b. City, Town, or	2. Date of De Month	Day 18	Year 2004 07:00 AT Tyof Death
-	Funeral	r	5. Social Security Number 217-35-9008 10		(In yrs. last birt				N/A	9. Birthplace (State or Foreig UKRAT NE
	ter death with the Maryland items 23a or 28a-f show ther must be notified at	ector	10a. State 10b. County N/A		10c. City, Town	10RE				10d. Inside City Limit:
	th with t	al Dir	10e. Street and Number 6900 PARK HEIGHTS	AVE # 206		10f. Zip		-	10g. Citizen of USA	What Country?
020	72 hours after death with the Marylend naturel', or items 23e or 28e-1 show dicel Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec	ent of Hispanic Origin? (Sify Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Ra Bla Specii	ce - American Indian, ack, White, etc. fy: WHITE
21215-0020	d within 72 ho giene. r than "natur r e Madicel	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	-)	Decedent's Usua (Give kind of wor life. DO NOT us	l Occupation k done during most of wo e retired)	rking		Business/Industry
Maryland	ould be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) EMANUIL		KLOPOU	IKH	BELLA	me (First, Middle,	Maiden Sumai (UN)	ne) (NOWN)
	and 2 sh alth end 27 is m or traum		19a. Informant's Name/Relationship (7) MR. ALEXANDER KLOP((Street and Number or R ROAD OWINGS			
Baltimore,	Peges 1 at the ment of He tant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemeter	Disposition (Name y, crematory or of TON-CHIZ	UK AMUNO 1	Date /19/04 B	ALTIMOR	
Ra	Depari Depar Impor any In		21. Signature of Funeral Service Liceus	attle	in .	8900 RE	ISTERSTOWN	ROAD PIK	ESVILLE	ROS. INC. E, MD. 21208
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Division of vital necords,	law require les been sig e 2 should b	Completed t	Peripheral Vas	dent dia Cular a	Is Cas-	0		24a. Was a perfor	n autopsy med?	24b. Were autopsy findings available prior to completion of cause of deeth?
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5	pital or Atl rurs efter d arsi Direct illed in by	Certifi	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)			City or Town	n, State)	er or Rural Route Number,
	To the Hospital or within 24 hours effe To the Funersi Dir completely filled in	edicai	one)	ician: To the best of a ler: On the basis of ea and manner state	xamination and/	death occurred at for investigation, i	the time, date and place n my opinion, death occu	, and due to the carred at the time, d	ause(s) and ma ate and place,	inner as stated. and due to the cause(s)
	Tot Tot Com	Σ	29b. Signature and title of certifier	the	moli	1/10	License number			d (Month, Day, Year)
1	6		30. Name and address of person who con	mpleted cause of dea	th (Item 23a) (T	ype, Print) 401 1/1.10	of Relientors	Avenue	Balli	y 18,2004 nove MD 21215
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	and E	I ISTIVE US	11101110	-4/11/	1110 -123

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hysician		Decedent's Name (First, Middle, La								2. Date of De Month	ath _ [)ay Year	3. Time of Death
/Medical	1	Elaine Butler				1				January	/,		9:40 p
Examiner	r '	Sta. Fecility Name (If not institution, given State 11 a. Marsia, Hac						Location o	of Death			c. County of Deat Baltimor	
		Stella Maris Hos			. last birthday)		noniı r 1 Yəar	IIII If Under:	24 Hrs	O Data of Bia			
ineral rector			1 ☐ M 2 🗗 F	82	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da April	14°,	1921 Ma	hplace (State or Foreig untry) ryland
Mo ma	-	10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
Important: If item 27 is marked other then "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Le notified at ones. To Be Completed by Funeral Director	5	Maryland			Ba1	timor	re Ci	itv					1¥ Yes 2 No
irec	ב	10e. Street and Number	· ·			10f. Zip					10g. (Citizen of What Co	untry?
ritems 23a or 28a-1 s riter rital be notified Funeral Director	2	325 Gusryan Stree	t				2	L224			U	.S.A.	
I Par	2	1. Marital Status	12. Was Deced	lent Ever in I	U.S. 13.	Was Deced	dent of H	ispanic Original	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ame Black, White	
		1 ☐ Never Married 2 ☐ Married	1 Tes 2	No No		1 🗆 Yes			i, r ddito i	iloan, etc.)			
dby dby		3 ☑ Widowed 4 □ Divorced	Year or Dat			103	242 140	орвену.				Specify: whi	te
rt, the Medical I	ט ע	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo	al Occupa	ation during most I)	t of workir	ng		Kind of Business/	
a Ma	5	Elementary/Secondary (0-12)	College (1-	4or 5+)			se retired)					ity Board
f. C.	3	17. Fethada Nama (First Middle Jaco	<u>T</u>		Teac	ner	-	10 14-45-	4- 11			Educatio	n
> B	ו ב	17. Father's Name (First, Middle, Last								(First, Middle,			
To last	_												
raum		19a. Informant's Name/Relationship	Type, Print)		10								•
Tet.			hter	20%				Place					
o o	1		Removal from S	tate	cemetery, crei	natory or o	other plac			175			
iuny		*4 □Donation 5 □ Other (Speci	(y)	0a				1					
eny in		Emmett Wesley Butler 19a. Informant's Name/Relationship (Type, Print) Sharon Kelly-Daughter 1411 Ard-Brac Place Salisbury, Maryland 20a. Method of Disposition 1 Spurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of commetery, crematory or other place) 0 Ak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Science of Commeters and Address of Facility Charles S. Zeiler & Science of Commeters and Address of Facility Charles S. Zeiler & Science of Commeters and Address of Facility Charles S. Zeiler & Science of Commeters and Address of Facility Charles S. Zeiler & Science of Commeters and Address of Facility Charles S. Zeiler & Science of Commeters and Address of Facility Charles S. Zeiler & Science of Commeters and Com											
● d	1	23a. Part . Enter the disease, or comshook, or heart failure. List only	1088		162	24 Ea	astei	n Ave	enue	Baltim	ore	, Maryla	nd 21224
by Physician/Medical Examiner	Lyalli	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a conse	quence of):								
्रह्म २			_ d										
be detached for use as ti by Physician/Med	ysicianum	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ∏Fet ntattime of	aldeath 3□	Ectopic pr Other (sp						23d. Date of deli	very Day Year
PP PP	F	Part II. Other significant conditions	contributing to dea	th but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
ב ק	2									101	es :	2 □No 3 □ Pro	bably 4 X Unknown
ieted										24a. Was		045 144	
page 2 should	2				· · · · · · · · · · · · · · · · · · ·					autop	sy med?	prior to c death?	opsy findings available ompletion of cause of 2□ No
Be	3	25. Was case referred to medical examiner?	Hospital:		_		I on	_		Check onl o			
To To		1 Yes 2 XNo	1 □ Inj 28a. Date of		28b. Time of		Card-lenner	4 🔾 Nui				6 Mother (Spec	(fy) HOSPICE
he funer	100	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	M	8c. Injury Work 1 □ \	at ? /es 2 □ N		8d. Describe h	iow inf	ury occurred				
led in by the funera Certification:		3 Suicide 6 Could not be determined	200. Place 0	f Injury - At h g, etc. (Speci	nome, farm, str ify)	eet, factory	, office		2	8f. Location (5 City or Tox		and Number or Rui te)	ral Route Number,
completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	Ballo	29a. Certifier (Check only one) (Check only one)	nysician: To the b miner: On the bas and manne	is of examin	owledge, deatl ation and/or in	occurred vestigation,	at the tim , in my op	e, date and pinion, deat	d place, a h occurre	nd due to the o	ause(s) and manner as nd place, and due	stated. to the cause(s)
completely filled in by the		29b. Signature and title of certifier)			290	. License	number			29d. D	ate signed (Month	. Day, Year)
			/11=	_			DU	27	2.0	_		1/8/0	4
T		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Tvoe	Print)	-	/	2				/
10					/(1700,								

DHMH 17 Rev 1/2001

9:40 р.ш.

JANUARY 7, 2004

ELAINE KELLY

CPM 04-00240 BENEDICT LOUIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iev.	ICI LOO	15 1	Stote Amend Item#	State (26perMEOG82	of Maryla 7 1/21/20	and / Depa 004 EW _{Cel}	artment of H tificate of	lealth and Death		giene 20	04	01242
			Decedent's Name (First, Midd	lle, Last)					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia		Benedict		Lo	ouis			January			18:13 M
	/Medic Examin	-	4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town, o	r Location of Deat		4c. County	of Death	
			508 North Cast	le Street				Baltimor		NA		
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	9. Birthp	place (State or Foreign htry)
	Director		216-62-0403	1 X M 2□ F	69	Yrs.			1-15-	34	St.	Lucia
	pu .	-	Usual Residence of Decedent 10a. State 10b. Count		10c	City, Town or Lo	cation				1	0d. Inside City Limits
	aryla				1.00.		timore					1X Yes 2 □ No
	Ba-f	cto		IA		Da1	10f. Zip Code			10g. Citizen of V	Vhal Cour	ntry?
	or 2	Die	10e. Street and Number				TOT. ZIP COUR	21205		USA		,
	hours after death with the Maryland turel; or flems 23s or 28s-f show a Examiner must be notitied at	Funeral Director	508 North Cas		cedent Ever in	2118 13	Was Decedent of H		Specify Yes or No		e - Ameri	can Indian,
	er de	nu	11. Marital Status	Armed F	Forces?	10.0.	Was Decedent of H f Yes, specify Cubi	an, Mexican, Puer	to Rican, etc.)	Blac	k, White,	elc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	i If Yes. C	ive		1 ☐ Yes 2 🔀 No	Specify:		Specify	Bla	ick
응	hou	ed	15. Decede	nt's Education		16a. Dece	tent's Usual Occup	pation	. data a	16b. Kind of Bu	siness/In	dustry
15	in 72 n nat	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	life.	kind of work done DO NOT use retire	d) most of wo	irking			
212	s within liene. r then	Eo	5th grade	Conego	(1 40. 51)	Weld	der			Beth.		21
b	be filed within 72 hours after death with the Marylan Hydione, Hydione, do thydione, or a terms 23a or 28a-f ehow other than natural, or ttams 23a or 28a-f ehow event, tre Medical Examinat mant be notified at	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's Na	me (First, Middle	, Maiden Sumam	(8)	
lan	lid be lental rked c	To B	Agustus			Louis		Unkn				
Maryland 21215-0036	s 1 and 2 should be f f Health and Mental I frem 27 is marked of other traumatic eve		19a. Informant's Name/Relation				ng Address (Street					Code)
Σ	alth a 27 is		Geneva Louis	Wife			N. Castle	e St., Ba			1205	
Baltimore,	permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any injury or other traignce.	. 1	20a. Method of Disposition	2 CRamouslites		 b. Place of Dispo cemetery, crei 	sition (Name of natory or other pla	ce)	Date	20c. Location -		_
Ę	Page ent c nt: If ry or	1	1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (G	reenmou	nt Cem.	1-15	5-04	Baltimo	re, N	id.
alti	mit.	Ì	21. Signature of Funeral Service	e Licensee		2:	2. Name and Addre	•	Balt	imore, I	Md.	21202
m	Department of the post of the		Bemay o	D Jumos)		March F.H		1101 E.	North A	ve.	
	M 65.		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications tha	t caused the d	leath. Do not en	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	- Pnysician		Immediate Cause (Final disease or condition	9.,	wa	ke	Tarke	lation			1	Onset and Death
	/Medical		resulting in death)	a. Due t	o (or as a con	sequence of):	1-1-10	0 100				
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	outed Id ransli	Examine	that initiated events) c								
ó	an ar rial-t	EX	resulting in death) Last	Due t	o (or as a con	sequence of):						
8760,	The law requires that the death certificate be executed the sabeen signed by the attending physician and tate 2 should be detached for use as the burial-transit	dical		d								
9	ntifica ng ph as th	Jed	IF FEMALE:									
X	eath certific attending p	an/Me	23b. Was decedent pregnant		outcome of pre birth 2 F	Fetal death 3	Ectopic pregnanc	y		23d. Da	te of deliv oth	ery Day Year
. B	dea ne att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pre 9 □ Uni	gnant at time known	of death 5	Other (specify)					·
P.0	at the de by the	Physici	9 Unknown			Mi i M-		uan in Dart I	23a Did	ohacco use cont	ribute to 1	he cause of death?
Ś	es that gned to be det	by	Part II. Dther significant condi	tions contributing to	geath but not	resulting in the t	inderlying cause gr	ven in raiti.	1 _	Yes 2/10/No	3 ☐ Pro	
ecord	w requires been signe should be									765 27710		
၁၁	e law r has be je 2 sh	Completed							24a. Was auto	psy	prior to co	opsy findings available empletion of cause of
$\mathbf{\alpha}$	The late has page	no							1 Yes		death?	2□ No
Vital		Bec	25. Was case referred to medic examiner?	cal					eath (Check only	one)		
f V	S 5	2	1X Yes 2 □ No	Hospital:	☐ Inpatient	2 ER/Outpatie	nt 3LI DOA		Home 5 ☐ Res			fy) Scene
n of			27. Manner of Death 1 □Natural 5 □ Pend	/4.4	e of Injury onth, Pay Yea	28b. Time of Injury	Wo		28d. Describe	how injury occur	red	() 0
Division	Attending r death.	Certification;	Accident inves	stigation //	9/04	1711		Yes 2/2/No	VICTOR	- Of te	xus c	tore
<u>×is</u>		tific	3 ☐ Suicide 6 ☐ Could dete	minor 200. 11 16	iding, etc. (Sp	Al home, farm, st	reet, factory, office	51	28f. Location (Street and Numb wn, State)	er or Rur	al Route Number,
	tal or A	Cer				My HU	me		1208V	· Cas J	169	T. 4200
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier 1 ☐ Certifi (Check only 2 ☐ Medic	ying Physician: To al Examiner: On the	basis of exar	knowledge, dea mination and/or in	th occurred at the to execute the total occurred the total occurred to the total occurre	ime, date and plac opinion, death occ	curred at the time.	cause(s) and ma date and place,	and due	stated. to the cause(s)
	To the H within 24 To the F complete	Medical	one A	and m	anner stated.			se number		29d. Date signe		
_	To Too	2	29b. Signature and title of genti	ter / Ali	1							
	,			ve M			0.	C.M.E.		January	10,	2004
	6		30. Name and address of person	on who completed o	death	(Item 23a) (Type		root Ba	ltimoro	Marrelar	va 21	201
	U		JUHAN	WILL.	M)		Penn St	reet, Ba	тслюте,	патута	KL 21	.CU1
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye.	9 1 2000	. Registratio S	algnature	P ANDE B					

	_1	For State Registrar	State of Marylan		epartment of H Certificate of L			Reg. No. 200	4 0124
Physiciar /Medica Examine		1. Decedent's Name (First, Middle, MAUNICE Sa. Fecility Name (If not institution, SUBUL DA	Levin son, give street and number). In Hospital	n 1	4b. City, Town, or Betne	sda		Day Year 1 0 04 4c. County of De. Montgo	ath evy
Funeral Director		5. Social Security Number 468-01-4811 Usuel Residence of Decedent	7. Age (In yrs.)	ast birtho	Months Days	If Under 24 Hrs Hours Min		th y, Ygar)_ (9. Bi	rthplace (State or Foreign Country) sachusetts
with the Maryland or 28a-f show		10a. State 10b. County MD Montgo			r Location rer Spring 10f. Zip Code			10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes ※ No Country?
within 72 hours after death with the Maryland ene. then "natural", or Itema 23s or 28s-f show he Medical Examiner must be notified at	מומומו	3602 Chorley 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?	S.	2090 13. Was Decedent of His If Yes, specify Cubar 1 □ Yes XX No		Specify Yes or No- to Rican, etc.)	04	ericen Indian,
ed within 72 hours afl ygiene. her than "natural", or it, the Medical Exam		15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	(C	ecedent's Usual Occupa Rive kind of work done de. DO NOT use retired, hanical Eng	uring most of wo	rking	16b. Kind of Busines:	
d 2 should be filed the and Mental Hygis 7 is marked other traumatic event,	מ	17. Father's Name (First, Middle, La Isadore Levii 19a. Informant's Name/Relationshi	ist) 180hn		lailing Address (Street a	18. Mother's Na Ida		Maiden Surname)	Zin Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating must be notified at DOC.		Marcia G. Levin 20a. Method of Disposition 1X Burial 2 Cremation 3 14 Donation 5 Other (Spe	nsohn (Wife)	36 ace of D emetery,	02 Chorley isposition (Name of crematory or other place Israel Cen	Woods W			MD 20906 r Town, Stete
permit. F Departm Importar any injur		21. Signature of Funeral Service Li	A		22. Name and Address Hardesty 12 Ridge1	s of Facility Funeral y Avenu	Home, P e, Annap	.A. olis, MD 2	
Pnysician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly office cause on each line. SUBOUND H Due to (or as a consequence)	AME	bud				Interval Between Onset and Death
ate be executed hysician and the burial-transit	Icai Evailli	Sequentially list conditions, if any, leading to immediate cause Earth Lerby in Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o						
nat the death certifica d by the attending phetached for use as the behalf of the death of the d	yaiciainmed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	slivery Day Year
w requires that been signed be should be deta	2	Part II. Other significant condition		ilting in th	e underlying cause give	n in Part I.	23e. Did to		to the cause of death? Trobably 4 □Unknown utopsy findings available
cian: The law requires entilicate has been signs etter, page 2 should be	U	25. Was case referred to medical examiner?				26. Place of De	autop	prior to death? 2 No 1 Ye	completion of cause of
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the modern of the funeral director.	2	1	28a. Date of Injury (Month, Day Yeer) tion 1 2 0 4 28e. Place of Injury - At ho	28b. Tim Inju VWW me, farm	ry Work ドルル M 1 ロ Y	at ?	28d. Describe h SUPPEO 28f. Location (5	dence 6 Other (Spanow injury occurred FBU TO FUE Street and Number or F	op,
24 hours afte Funaral Dir etely filled in	edical cell	29a. Certifier 1 ☐ Certifying	building, etc. Specify Physician: To the best of my know eminer: On the basis of examinat and manner stated.	vledge, d	eath occurred at the time r investigation, in my op	e, date and place inion, death occi	a, and due to the o	cause(s) and manner a	s stated
To the vithin: To the comple	A	29b. Signature and title of certifier	ma (ont))		number 234		29d. Date signed (Mon Thurst 16,	* '
State		31. Date filed (Month, Day, Year)	FUKE CONVICTOR IN 32. Registrar's Signal	0 20 ure	855 (Her		oto, mo.		
Registral		গুল্মা 🕏 গু	2004	ORIG	INAL ANARA	27			

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 2 should be f and Mental h Box 68760, P.0.

and

the attending physician

signed by

certificate

After

death.

after death

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 01244 State Registrar Amend Item #11 per fh G827 1/21/04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician aullein 2004 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore 04 pita If Under 1 Year If Under 24 Hrs. 8 Date of Birth Months Days Hours Min. Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece State or Foreign **Funeral** 10 M 20 F -24-2675 Director KOX Usual Residence of Decedent 10b. County State 10c. City, Town or Location 10a 10d. Inside City Limits 28a-f ahov item 27 is marked other than "naturel", or items 23a or 28a-f abov other treumstic svent, If a Mudical Examinal must be notified at Yes 2 No Director mus 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 1 ☐ Yes 2 No a 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DRew Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur, Be 2 rmant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 🚉 permit. Pages 1 and 2 Department of Health a Importent: If item 27 it any injury or other tre Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State natory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dogation 5 □ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Ou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eumou da /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: burial-transit Due to (or as a consequence of): Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's agnature

31. Date filed (Month, Day, Year)

Physician

/Medical

Examiner

Funeral

Director

23e or 28e-f show

filed within 72 hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed wi Degartment of Health and Mental Hyglen Importent: If item 27 is marked other th any injury or other treumatic event, the

Director

Funerai

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Completed

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signed I Be ٩

Completed by Physician/Medical

27. Manner of Death 1 ☑ Natural 2 ☐ Accident Medical Certification:

1 ☐ Yes 2 No

3 🔲 Suicide

29a. Certifier

4 T Homicide

30. Name and address

29b. Signature and title of pertifier

31. Date filed (Month, Day)

AUVERAHALLI

5 Pending investigation

6 Could not be determined

On W

After thi Director: /

certificate

this

within 24 hours after or To the Funeral Direct completely filled in by

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. PAYSICIAN.

of person and completed cause of death (Item 23a) (Type, Print)

HARISH-

2003 Registrer's Signature

1 Dipatient

28a. Date of Injury (Month, Day Year)

42723

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) JANUARY 2004 1

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CEMIER NORTHWEST HOSPITAL OLD MD 21133 5401 COURT RUAD

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Pairent known as Virgie dewis

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🛭 🛭 🛴 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lew: Year LP 119 janua 5 2004 19:55 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) 216.24.9185 1□M 2 1 F Days Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Funeral Director 1 ☐ Yes 2 ☐ No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? > Du thaby 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 10 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1eache 3AL7, more 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ohn Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trau M. Lew. Husband 2413 Loyola Southerry BACTIMOSE Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11-21-04 BALtimore Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Addr s of Facility Queha C Greene Honeral Sewices Liberty Road RANDAUStoan 23a. Part1. Ener the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** day /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 M No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / I in by the fi 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) COUK aution 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

			For State Registrar	State of M	/arylan		artment rtificate			and M	-	giene Reg. No.	04	0 1 2 4 7
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	/Medio Examir		4a. Facility Name (If not institution,		or)		4b. City, T	Town, or	Location o	of Death	- Ganaa.		ity of Death	
			1008 Magnolia						towne	:		Ha	rford	<u> </u>
ı	Funeral Director		5. Social Security Number 215-03-5551	6. Sex 1 □ M 2√√F	Age <i>(In yr</i> s. 91	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 2	, 1912	9. Birth Cou Mar	place (State or Foreign intry) Tyland
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
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Mary	s 1 and 2 should f Health and Men item 27 is marke othar traumatic		19a. Informant's Name/Relationsh		+02)		ng Address				I Route Number	or, City or Tow		
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Baltimore,	permit. Page Department of Important: If any injury or once.		*4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		6	7. 22	Name and	Addres	s of Facilit	Fune	ral Hon	ne, Inc		
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ion	or Attending Physician: after death. Director: After this certific in by the funeral director,	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	ation	Day Year)	Injury	м	lc. Injury Work 1 Y	?`` 'es 2 □ l		.ou. Dogaribo i	ion injury cook	11.00	
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	shov	7	10a. State 10b. County Maryland Baltimor		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 1 No
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Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Furieral Service Licen	S88					nore, Maryl	
	20559		Vssa S. Jy	govie	ens Avenue	Baltin	ore, Maryl			
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Baltimore,	permit. Page Department Important: If sny injury or		21. Signature of Funeral Service Li	censee		2:	Name and Address Hardests 12 Ridge	ess of Facility Funera Ly Ave	al Home, P. nue, Annapo	A. Dis, M	214	01	
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		JOHNS HOPKINS	Lawiew		Balti	more		N/A					
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and *		Usual Residence of Decedent 10a. State 10b. County	10	C. City, Town or	Location			1	10d. Inside City Limits				
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	era	11. Marital Status				21205	Specify Yes or No-	U. S. A. ecify Yes or No- 14. Race - American Indian					
	Funeral Director	1 ☐ Never Married 2 Married		Was Decedent of H If Yes, specify Cub. □ Yes 2 No.		rto Rican, etc.)	Rican, etc.) Black, White, etc.						
urs e	b	3 Widowed 4 Divorced	/idowed 4 □ Divorced If Yes, Give Year or Dates:			Specify:		Specify: White					
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should be filed within of Mental Hygiene. I marked other than unaite event, I'm Mental Hygiene.	2	David W. Robinso					nnys Rut						
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S 1 end of Health Item 27 other tr		Deward L. Mangus	· · · · · · · · · · · · · · · · · · ·					Maryland 21					
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Dallillo permit. Peges Department of Important: If It any injury or o		'4 □Donation 5 □ Other (Speci	1	Parkwo	od Cemeter			Baltimore, 1					
Denmil Departimon Importanticon		21. Signature of Funeral Service Lice	DSOO		22. Name and Addre			Funeral Hon					
		flam./l		1 1 5				re, Md. 2121					
The law requires that the death certificate be executed XB/V SB/V SB/V SB/V SB/V SB/V SB/V SB/V S		23a and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	12 OK	nea estruct	ivepu	Imonar	y disease	aays . years				
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		23d. Date of delivery Month Day Year								
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ysici s cer direct	0 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: Impatient	2 ER/Outpat	ient 3 DOA Oth	Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
g Physe er this eral dir	n:	27. Manger of Death	28a. Date of Injury	28b. Time	of 28c. Injur		28d. Describe how injury occurred						
ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigatio		(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No									
or Atte after dea Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai C												
To the To the To the To the Comp	Ž	29b. Signature-and title of certifier			29c. Licens	e number	29	9d. Date signed (Month, I	Day, Year)				
		tama	Tatel N	10	23	3011	A	January 19,					
10		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	e, Print)								
V		YOHNS HOPKINS	s Baynen	1 Med	ical (enter							
St	ate	31. Date filed (Month, Day, Yang)	2 1 2007 egistrar	Signature	de South	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 2004 810 6. Mc C 1101 /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mere. 621 Baltimore N/A If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Pay, Year) NOV. 13, 1919 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2□F 84 215-03-1400 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or items 23e or 28a-f ahow any injury or other traumatic event, the Modical Exemples must be notified an once. 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3905 Darleigh Rd., Condo 1B 21236 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Sargeant 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be William Jobe McCurdy Miller Clara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Miss Joan McCurdy (daughter) 4609 Ballygar Rd., Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 1/21/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Foneral Service License 9705 Belair Rd., Baltimore, MD 21236 23a Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** L /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months?

1 Yes 2 No
9 Unknow for Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has neveroni 2 No 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Other: npatient Certification: To 1 🗀 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deal 1 Alatural 2 Accident 28a. Dulle of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injun 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

DHMH 17 Rev 1/2001

Registrar

20

32. Registrar's Signature

			1 - For State Registrar		Maryla	•	artmen rtificat				lental Hy	Reg. No.	200	1	012	252
	Physic	ian	Decedent's Name (First, Middle	Table 1			McCoy				2. Date of De Month		Day Year		3. Time of	
	/Medi	cal	Nellie	M			45 05.			-4 D+h	January 16, 2004 06345 AM					
4	Examir	ner	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital					4b. City, Town, or Location of Death 4c. County of Death Baltimore								
	Funeral Director		5. Social Security Number 216-24-3310		7. Age (In yrs. last birthday)						8. Date of Bir (Month, Da		9.	Birthpla Country M	ce (State or r) D	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							100	I. Inside Cit	h/ Limite
	daryli f sho	5		A		altim								100	1 X 1Xes	
36	28a-	rect	10e. Street and Number 10f. Zip Code 10g. C								10a. Citi	Citizen of What Country?				
	3a or	<u>=</u>	2310 Longwood Street					21216					U.S.A.			
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it a Medical Exart it and traumatic event, it as Medical Exart it and traumatic event, it as Medical Exart it and the contributed at	by Funeral Director					Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XXNo Specify:						14. Race - American Indian, Black, White, etc. Specify: Black			
Ö	2 hou	ed	15. Decedent's Education 16a. Decedent's Usual Occupation					ition			16b. Kii	Kind of Business/Industry				
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nd	2 should be filed within and Mental Hygiene. is marked other than "raumatic event, the Men	Be	17. Father's Name (First, Middle,	•							(First, Middle,	Maiden	Sumame)			
Σ	ould Men varke	၉	James Goldrin								utler					
Maryland	od 2 sh Ith and 27 is n 'traun		19a. Informant's Name/Relationsh			1					/ Route Numbe				ode) 212	16
	1 and Health em 27		William J. Mc 20a. Method of Disposition	Coy-Husb		2310 Place of Dispo					et, Ba		cation - City		-	10
ē	ages ont of t: if it		Varial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (St		ialo				1		1/21/					
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other ance.		21, Signature of Funeral Service I		AL				,						Ma	
B	Depa impo any ii		Kala	Mary	4	4	368h	Waba	ash we	st Ave,	Balt	imor	e Md	2	1215	
			21. Signature of Funeral Service Licensee 22. Name and Address of Facility March Fy H West 4300 Wabash Ave, Baltimore Md 21215 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											, ,		
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4	/Medical		resulting in death) Due to for as a consequence of): Sequentially list conditions b. Coronary Attery Disease								2 ho	MAS				
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Vital		Be C	25. Was case referred to medical examiner? 26. Place of Death							of Death	1 ☐ Yes 2 Ø No					
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			27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month,												
isio	Attending r death. sctor: After by the fune	cat	2 Accident investig 3 Suicide 6 Could n	ot be One Blace o												
Division	F 0 E E	Certification:	4 ☐ Homicide determi	ned 289. Flace o building				28f. Location (Street and Number or Rura City or Town, State)				Hurai H	oute Numbe	∍ <i>r</i> ,		
\nearrow	To the Hospital or within 24 hours aft To the Funeral Di completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated.								d. e cause(s)					
	To the within 2 To the Comple	Me						29c. License number D0059290 Tarkway Baltimor					29d. Date signed (Month, Day, Year)			
	11		hd	dies M	0			D	0050	1291	0 "	Jam.	0 1.1	110	200	4
	10		30. Name and address of person v	who Impleted cause	of death (Iter	n 23a) (Type,	Print)				111	/cr Iu	cry	101		L
	1		Bettina Adjes	201 Eas	stolle	uversi	Ly Pa	irku	vay	Bal	hmore	= M	aryla	nd	2121	8
di. Ref	Sta Registr		31. Date filed (Month, Day, War)	2 1 2004 Reg	gistrate's Signa	ature &	A STATE OF THE PARTY OF THE PAR	N.	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Amend Item #18 per fh G827 1/21/04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Year HERSH MARKOWITZ 08:00AM /Medical 18 2064 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Belt Moder 24 Hrs.

Months Days Hours Min. N/A hospitel Sinci Social Security Number 8. Date of Birth (Month, Day, Year)
DEC 21, 1932 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 219-32-8736 1□**X**M 2□ F 71 Director NY. Usual Residence of Decedent Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or Item 27 is marked other than "natural" or Item 27 is marked other than "natural". 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD N/A Completed by Funeral Director BALTIMORE 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3023 GLEN AVE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify:WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RABBI RELIGION 17. Father's Name (First, Middle, Last) SOLOMON 18. Mother's Name (First, Middle, Maiden Sumame) Be CHANA Chana Hirshbein MARKOWITZ HIRSCHBEIN 19a. Informant's Name/Relationship (Type, Print)
MRS. BARBARA MARKOWITZ/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3023 GLEN AVE BALTIMORE, MD. 21215 20b. Place of Disposition (Name of KOVNA 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) JAN.19,2004 ROSEDALE, MD. 21. Signature of Funeral Service. 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ocstolytestical /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 2/2 No r: After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မှ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification; 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Diractor: / 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 MD January 18,2004

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Assisted of Boldinare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004 Registrare Signature

		1 - For State Registrar	State of Ma	arylan	d / Dep	artment rtificate	of He	alth a	ind Me	ntal Hy	giene Reg. No.	200	2 7 7000
Physic /Med Exami	ical	Decedent's Name (First, Middle, La Marie J. Plewack Aa. Facility Name (If not institution, given Manor Care Rossy)	re street and number)			4b. City, 1			Ja	Date of De Month	7 16, 4c. C	Year 2004 ounty of Deat	
Funera Director		5. Social Security Number 6. S 218-05-9185		96 (In yrs. I	ast birthday, Yrs.	If Under	seda. 1 Year Days	If Under 2 Hours	24 Hrs. 8. Min. 2	Date of Bi Month, Di / 12/1		ltimor 9. Bird Mar	e hplace (State or Foreign whity) Yland
e Maryland 3a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltima	ore		r, Town or L edale	ocation					_		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
eth with th	Funeral Director	1318 Rosewick Ave				101. Zip	212	237			USA	en of What Co	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at any injury or other traumatic event, the Madical Examinar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		S. 13.	Was Deceded If Yes, special Yes 2			gin? (<i>S</i> pecif , Puerto Ric	y Yes or No an, etc.)		. Race - Ame Black, White pecify: Wh	e, etc.
within 72 haliene.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or t	5+)		dent's Usual kind of work DO NOT use sekeep		on ring most	of working			of Business/ ement	Industry Church
ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last John Nowicki					1	Stel	la Bu	nker	, Maiden S		
Health and tem 27 is mother traum		19a. Informant's Name/Relationship Thomas Plewacki 20a. Method of Disposition		20b. Pf	712 I	ing Address Falcone position (Name of the Indian Property of the Ind	er Ro	l. Jo		wne,	MD. 2	Town, State, 2 1085 Ition - City or	
permit. Pages Department of Important: If it any injury or o		t Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Sentice Lice	fy)	St.	Stanis	staus (Cemet	ery				imore, Funera	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit on the page 2.	Ical Examiner	23a. Part Emily the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d	a consequ	uence of):		, -						Approximate Interval Between Onset and Death Sulface Onset Approximate Onset Approxi
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[⊒Ectopic pre ⊒ Other (spe					23	d. Date of deli Month	ivery Day Year
law requires that as been signed b 2 should be dete	ted by Pł	Part II. Other significant conditions	•	ut not resu	ılting in the u	inderlying ca	use given	in Part I.			tobacco use		the cause of death?
ician: The law r sertificate has be ector, page 2 sh	e Completed by	Of Managed to add a								1 ☐ Yes	ormed? 2 ☐ No	death?	topsy findings available completion of cause of 2 No
nding Physicia ath. r: After this certi e funeral directe	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man 1 Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	irv	ER/Outpatie 28b. Time o Injury		Other: Sc. Injury a Work?	4 Nur	280	5 🗆 Resi		Other (Spec	city)
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7 with 50	-	29b. Signature and title of certifier	wn			1	License i		-			signed (Mont)	**
')		30. Name and address of person who	in uno	750	20 7	CER	On	UE	Tov	いろしへ	t w	10	21204
Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registr	of John Control	ANDA	whi							

TRWACK

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Essie **Phillips** 6:00 Pm. Jan 15, 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Loerien Nursing Home Frankfort Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2X□ F 246-18-1254 86 NC Director Apr 19, 1917 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **ehow** or items 23a or 28a-f show there, sust be notified at 1 Yes 2 No N/A **Baltimore** Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1932 E. Lafayette Ave 21213 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 TX Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural', ar then "nature". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental ie marked Jessie Harvey Marion L. Green ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is eny injury or other trau once. 1932 E. Lafayette Ave Baltimore, Maryland 21213 Robert Phillips Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/22/04 Owings Mills, Maryland 4 □ Donation 5 □ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature, of Funeral Service Licensee Estep Brothers Funeral Home P.A 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1300 Eutaw Place Baltimore, MD 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Ninknown ON 2 KSAIROMETT 1 🗌 Yes 2 🗆 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed Yes 2 certificate ŽQ∕No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 3□ DOA ္ 2 ER/Outpatient this tuneral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2/ Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASAR 308 THUA NEUZAW STREET, STE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2004 Registrar

Mary E. Pratt Day Vest April Day Vest County of Death April County of Death April County of Death April County of Death April County of Death April April County of Death April			1 - For State Registrar 1. Decedent's Name (First, Middle, Last))		Ce	rtificate	ot D	eath	2. Date of De			3. Time of Death
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23a Part Enter he disease, or comparisons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Barveson as children interval Barveson or respiratory arrest, interval Barveson or continue soliting in death) 10	Departm Departm Importar eny injur					2:	2. Name and A	Address tep Br	of Facility others Fun	eral Home	P.A. MD 21217		
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Second S			23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 4 Pregnant at ti	Fetal	death 3							,
Second S	quires that I en signed by uld be deta	ρχ	~ / /	-	not resul	lting in the u	nderlying caus	se given	in Part I.				1 2
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature an Use of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	iing Phys n. After this funeral dii	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	f 28c.	Other: Injury a Work? 1 \(\text{Ye}	4 ☐ Nursing H	lome 5 Resi	idence 6 🗆 C		y)
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2 3 8	thin 24 ho the Fune rupletely fi	Medical	(Check only 2 Medical Exami one)	ner: On the basis of e	xaminati	riedge, deat on and/or in	vestigation, in	my opir	nion, death occu	e, and due to the irred at the time,	date and place	e, and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name /First Middle Last) 2. Date of Death 3. Time of Death **Physician** MAE JANUARY 18, IDA PFI.T7 2004 11:30 A^M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 130 SLADE AVENUE #221 BALTIMORE BALTIMORE If Under 1 Year Months Days If Under 24 Hrs. 6 Sex Dete of Birth Month, Day, Year NOV. 12, 1917 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs 213-12-0239 86 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r Items 23a or 28a-f show imer-wast by notified at 1 ☐ Yes 2 ☑ No /MD Director BALTIMORE BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 2 withingury or other traumatic event, the Medical Examinational Durie. 130 SLADE AVENUE #221 21208 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRAVEL AGENT TRAVEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY FINK KATY (UNKNOWN) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE PELTZ / DAUGHTER 130 SLADE AVENUE #111 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 1/20/2004 WOODLAWN, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Du astir Physician /Medical Due to (or as a consequence of): **Examiner** COVONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician the attending ph IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached t been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed: 1 Yes 2 No Hospital or Attending Physicien: Be (funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Anatural 5 Pending Injury within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6 Conversed; Baltimon, HA WILLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)/ 7000 old DA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	• •	d / Departme	nt of Health and Mate of Death	•	ne 2001 0105	8
	Physici /Medic Examir	cal	4a. Facility Name (If not institution, give	POSNER		y, Town, or Location of Death	JANVAR)	Oay Year 3. Time of Death 17 2004 11:26 to Country of Death 13 ALTIM	Am M
	Funeral Director		213 10 3/01	7. Age (In yrs. 1	Month	er 1 Year If Under 24 Hrs. s Days Hours Min.	B. Date of Birth Month, Day, Yea JAN. 21, 19	9. Birthplace (State or Fore Country) RUSSIA	-
	the Maryland 286-f show	rector	Usual Residence of Decedent		OWINGS M	ILLS	10a. C	10d. Inside City Lim 1 ☐ Yes 2 【X	
936	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "neturel; or Items 23a or 28e-1 show other treumatic event, the Medical Evant art must be retified at	by Funeral Director	4730 ATRIUM COURT 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	#125 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:		21117 edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 X No Specify:	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE	
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Baltimore,	Page nent c ent: If ury or		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	OHE		MEMORIAL 1/20	/2004 F	Location - City or Town, State REISTERSTOWN, MD	
Ball	permit. Departr Importe any inje		21. Signature of Funeral Service License	attle				& BROS., INC. ESVILLE, MD 21208	
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1/	the Hosp in 24 hou the Fune ppletely fil	Medical	one)	and manner stated.	ion and/or investigatio		ed at the time, date ar	nd place, and due to the cause(s)	
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1	0		30. Name and address of person who co	1 m Ida	RISH .	NORTHWE 5401 OLG	or Hose	ROAD MD 2113:	3
	Sta Registr		JAN 2 1 2004	32. Registrar & Signat					

		For State Registrar 1. Decedent's Name (F	irst, Middle. Last)				rtment of tificate of		2. Date of De	Reg. No	2001	3. Time of Death
Physici /Media		Eneida M.							January	16,		8:10 A
Examir		4a. Fecility Name (If no 7909 35th		street and number)			4b. City, Town. Rosed	or Location of Dea	ith	40	. County of Dea Baltimo	
Funeral Director		5. Social Security Number 219–30–722	0 1	7. Ag	ge (In yrs. la	ast birthday). 8 Yrs.	If Under 1 Yea Months Day			th 1915	9. Bird Co Pue	hplace (State or Foreignatry) erto Rico
-f show	tor		b. County Baltimor	e		Town or Lo						10d. Inside City Limit
3a or 28a al bench	al Direc	10e. Street and Number 7909 35th					10f. Zip Code 21237	7		_	izen of What Co	ountry?
Department of Health and Mental Hygiene. Important: If Item 27s or 28s-f show any injury or other treumatic event. If a Medical Exercit at most be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2X Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	11	Vas Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No into Rican, etc.)	-	14. Race - Ame Black, White Specify:HIS	e, etc.
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Medical was been signed by the attending physicien and Medical Indiana Indiana	ical Examiner	Immediate Cause (Fin disease or condition resulting in death) Security is a condition if any, leading to immediate, leading to immediate. Enter Underlyin Cause (Disease or injuthat initiated events resulting in death) Last	diate ng ry	Due to (or as Alzheim Due to (or as Due to (or as	er's	ence of): Diseas ence of):		cage				Onset and Death
ittending or use a	by Physician/Medic	IF FEMALE: 23b. Was decedent prointhe past 12 mo 1 □ Yes 2 ☒ No 9 □ Unknown	nths?	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	су			23d. Date of del Month	ivery Day Year
signed by the a d be detached t	d by Pt	Part II. Other significat	nt conditions con	tributing to death t	out not resu	Iting in the ur	nderlying cause g	iven in Part I.				the cause of death?
ate has been si page 2 should I	Completed										prior to death?	itopsy findings availab completion of cause o
certificate rector, pag	Be	25. Was case referred examiner?		lospital:				ther	eath (Check only o			
After this funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident	i ☐ Pending investigation	1 ☐ Inpati 28a. Date of Inju (Month, Da	ıry	ER/Outpation 28b. Time of Injury	28c. Inj	4 🗆 Nursing	Home XXResid 28d. Describe I			cify)
s after deatl	Certification:		Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	me, farm, stre	eet, factory, office	9	28f. Location (S City or Tox	Street an vn, State	d Number or Ru	ıral Route Number,
within 24 hours after of the Funeral Directompletely filled in by	Medical	29a. Certifier 15 (Check only 25 one)	Certifying Phys Medical Examir	ician: To the best ner: On the basis of and manner st	of examinat	vledge, death ion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
within 2 To the	Σ	29b. Signature and Aitle	CLA LL	long	111	P	1	6595		29d. Da	signed (Mont)	h, Day, Year)

			1 - For State Registrar	State of Maryla		artment of F			Reg. No.	004 0126
E	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edith Alvina Ryan					2. Date of De Month Januar	ry 17, 2	
)i	Examin	ier	4a. Fecility Name (If not institution, give s Manor Care Rossvi	lle		4b. City, Town, o Rose	dale		Bal	y of Deeth .timore
	Funeral Director		5. Social Security Number 6. Sex 214-14-3580		s. last birthday) 33 Yrs.	If Under 1 Year Months Days		in. 11/10	71920	9. Birthplace (State or Foreig Country) Maryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Bright of the marked other than "natural", or Items 23e or 28e-f ahow many injury or other traumatic event, Ita Mexical Examinar man be nytified at ance.	Funeral Director	10a. State 10b. County MD Baltimo 10e. Street and Number 1418 Spring Avenue	re	Rosedal	_e 10f. Zip Code	21237		10g. Citizen of USA	· · · · · · · · · · · · · · · · · · ·
0036	nours after de ural', or Items	by	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:	(Specify Yes or No erto Rican, etc.)	Specif	ce - American Indian, ck, White, etc. fy: White
-61212	l within 72 h iene. r then "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	tient's Usual Occup kind of work done DO NOT use retired	during most of t	working		ore City
yiana	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Raymond Gately				18. Mother's h	Name (First, Middle Barbara S	, Maiden Sumar	
е, маг	1 and 2 she Health and Sm 27 is m ther trsum		19a. Informant's Name/Relationship (Type John Martin Ryan 20a. Method of Disposition	Husband	1418			Rural Route Numb Rosedale Date	MD 2123	
Baitimore, Maryiand 21215-0036	permit. Pages Department of t Important: If Ite any injury or of once.		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Juneral Signature License	emoval from State Ga	cometery, crer ardens c	natory or other place of Faith . Name and Addre	01/ ss of Facility	21/04 Cvach/Ros	Raspebu sedale F	rg MD 'uneral Home
	Physician /Medical Examiner	L	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a conse	S A constant S A c		g, such as card	liac or respiratory a		Approximate Interval Between Onset and Death
	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	it any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
. D OX	o o	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 10 No 9 ☐ Unknown	ic. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
ກົ	The law requires that the tee has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions conf	ributing to death but not re	_		en in Part I.		tobacco use cont Yes 2 ☐ No	tribute to the cause of death?
		e Completed	25. Was case referred to medical				00 Diagonal S	1 ☐ Yes	psy ormed? 2/10 No	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
5	ding Phys n. After this funeral dir	To B	examiner? 1 Yes 2 Wo 27. Manner of Death 1 Natural 5 Pending	ospital: 1	□ ER/Outpatien 28b. Time of Injury	28c. Injun Wor	er: 4 ursing	Home 5 Resi 28d. Describe		
DIVISION	Atten	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str			28f. Location (City or To	Street and Numb wn, State)	per or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	(Check only	cian: To the best of my kr er: On the basis of examin and manner stated.		estigation, in my o	pinion, death oc		date and place,	and due to the cause(s)
	with Cor		29b. Signature and file of certifier		\ \D	29c. Licensi		62	1	d (Month, Day, Year)
E	Sta Registr		30. Name and address of person who con Tude Workers 1. 31. Date filed (Month, Dly, Year) JAN 2 1 2004	MD 784 32: Registrar's Sign	om 23a) (Type, CA) nature	fwood .	Road	Glen B	wrnie,	WD 51001

			1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of Hortificate of L	ealth and N Death	Mental Hygie		+ 0126
П	Physici	an	Decedent's Name (First, Middle, Last)					2, Date of Death Month	Day Year	3. Time of Death
	/Medic		Alvin Ray					Januery	10 2004	10
1	Examir	er	4a. Fecility Name (If not institution, give s	treet and number)	Limore	4b. City, Town, or	Location of Deeth		4c. County of Death	ו
			5. Social Security Number 6. Sex	a cof Dat	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	N/A	nplece (State or Foreign
	Funeral Director			M 2□F	86Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) Col	intry)
			Usual Residence of Decedent					May 17,	191/ IN	
	ylenc		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Mar.	tor	MD		Baltimor	re				1 Nes 2 No
	म के 82 क)ire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	72 hours after deeth with the Marylend natural', or items 23a or 28a-f ehow dical Examater must be tradified at	Funeral Director	3903 Callaway Ave	nue		21215		Ū	Jnited Sta	ites
	r dee	ne	11. Marital Status	Was Decedent Ev Armed Forces?/	er in U.S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or li	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 Yes 2 No	Specify:		Specify:	
21215-0036	hour tural		3 🖫 Widowed 4 ☐ Divorced	Year or Dates:	160 Dane	dent's Usual Occupa		1.00	Bla	
5	n 72 "ne"	Completed	(Specify only highest grade	completed)	(Give	kind of work done di DO NOT use retired)	uring most of worl	king	o. Kind of Business/I	
7	within iene. than	Juc	Elementary/Secondary (0-12)	College (1-4or 5+)		e Trooper		"	aw Enforc	ement
b	be filed within 72 hours after deeth with the Marylen nat Hygiene. Id other than "natural", or Hems 23a or 28a-f ehow event, the Medical Exame or must be coullised at	BeC	17. Father's Name (First, Middle, Last)			·	18. Mother's Nam	e (First, Middle, Mai	den Sumame)	-
a	should be nd Mental marked c	ToB	Robert Ray				Ollie	Bergin		
Maryland			19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	ig Address (Street a		ral Route Number, Ci	ity or Town, State, Zi	ip Code)
	1 end 2 Health a lem 27 ls		Ollie Taylor/Niec	е	3641	Forest H	ill Road	Baltimo	re. MD 212	207
altimore,	Se o L		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	amayal from State	20b. Place of Dispo			Date 20c	Location - City or T	
Ĕ	Pages nent of ant: If It ury or o		'4 □Donation 5 □ Other (Specify)	BILLOVAL HOIL STATE	Chesapea	ake Crema	tory	Jan 20 2004 B	eltsville	MD
alt	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service License	1 4/64	3986 22	. Name and Address		neral Alte		
8	70E 29	\$ 1	23a. Fart1. Enter the disease, or compli			8717 Gree	n Pastur	es Drive	Baltimor	e, MD Approximate
8760,	Physician but sicial physician and physician and sicial street st	ıl Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	drati	ch				Intérval Between Onset and Death Aday 2 days 2 days
P.O. Box 687	death certif e attending id for use as	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 if 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3 ne of death 5	Ectopic pregnancy Other (specify)			23d. Date of delik Month	/ery Day Year
	The law requires that the tee by the bas been signed by the bage 2 should be detache		Part II. Other significant conditions con bulinguam Hunza						co use contribute lo l	41
COL	w req beer shou	lete	penneutia 30	extension adder an	ncer	-		24a. Was an	24h Were aut	opsy findings available
Vital Records,		Completed by						autopsy performed 1 Yes 2	prior to co	ompletion of cause of 2 No
₹	Physician: rthis certifica ral director, i	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: patient	2 ER/Outpatien	Othor		h (Check only one)	- 50	
ō	Phys or this oral di): To	27. Manner of Death	28a. Date of Injury	28b. Time of	t 3 DOA 28c. Injury Work	4 Linuising H	ome 5 Residence		79)
ion	Attending I r death. ector: After by the funer	to	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	<i>'ear)</i> Injury		9s 2 □No			
o many	z e i i c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, lactory, office		281. Location (Street City or Town, St		al Route Number,
	To the Hospitel c within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of r er: On the basis of ex and manner state	camination and/or inv	occurred at the time restigation, in my opi	e, date and place, nion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	10.0		29c. License	2 1		Date signed (Month,	**
•	.1		1K. LA	MD.	PUI - 10	RES	- 000	Ja	nuary 1	11,2004
	0		30. Name and address of person who con ROLF KRENTE, MI	mpleted cause of dear	th (Item 23a) (Type, I	Print) OF BALTI	MORE		V	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Some?	60			

	1	For State Registrar	State of Marylan		ate of Death		ene 2001	. 012
	1	. Decedent's Name (First, Middle, L.	ast)			2. Date of Death	1	3. Time of D
ician		MITCHELL	,	Rus	K	JANVAR	Day Year	411 2
ical		a. Facility Name (If not institution, gi	ive street and number)		ity, Town, or Location of Deatl		4c. County of Dea	
ner	4		N 1		•	1	40. County of Dea	0/2
	-	JOHNS HOPKIN			der 1 Year If Under 24 Hrs.	9 Date of Righ	O Pie	thologo (Chata or
	2	213-64-5000	Sex 1 1 Age (In yrs. 1	Yrs. Monti		8. Date of Birth (Month, Day, SEPT, 2)	1953 M	thplace (State or ountry) ARIJLA
	-	Sual Residence of Decedent 0a. State 10b. County	10c. City	v. Town or Location				10d. Inside City
=	- 1	Manata da	1/4.	,,	0	- 1	~/	1 Yes
Funeral Director	Z	MARYLAND	NIA		DALTIMOR	ECII	1/	
吉	1	0e. Street and Number	10 0	10f.	Zip Code	5 / i	g. Citizen of What Co	ountry?
a	L	6600 GLE	NXDARR LOU	IRT	4/20	39	451	4.
ne	1	1. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was De	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
		1 ☐ Never Married 2 X Married	1 Yes 2 No		2 No Specify:			
þ		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	10.00	Epsilo Specify.		Specify:	LACK
Completed		15. Decedent's I (Specify only highest g	Education	16a. Decedent's U	sual Occupation work done during most of wor	ting 1	6b. Kind of Business	
pie		Elementary/Secondary (0-12)	, College (1-4or 5+)	life. DO NO	Tuse retired)			
E		Libridaty Coolingary (o 12)	/ VR	MAC	HINIST	9	BEVERAGE	= CAPITAL (
		7. Father's Name (First, Middle, Las	51)			ne (First, Middle, M		
Be		WALTER	_	DNEV	KAT	-15	1.11	ON
မ			Time Delet	MUSK	(2)	15	WA	RD
1	1	9a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ess (Street and Number or Ru	rai Houte Number,	City or Town, State,	ZIP COde)
1	3-	KARL KUSK	(OROTHER)	2726	HARLEMAVE	- BALT	MORE, MD	2/2/
	2	0a. Method of Disposition		lace of Disposition (i	Name of or other place)	Date 2	Oc. Location - City or	Town, State
		1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec	Hemoval from State	NATIONAL	LCEME. 01-	24-14	Aller	MARVII
	-	21. Signature of Funeral Service Lice		22 Name	and Address of Facility	71074	Fulton	1 1100
500	`		11. 1M/2 aus	2 705	and Address of Facility BR	OHN JR.	FUNERA.	L 140/1
ŭ.		Lehuch !	1. Wyllar					
	1 3	23a. Part 1. Enter the disease, or conshock, or heart failure. List onl	mplications that caused the death y one cause on each line.	n. Do not enter the n	node of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Betwe
		mmediate Cause (Final disease or condition	HINET	ATTAC	16			Onset and De
		esulting in death)	a. Due to (or as a consequ					a DA
r			200 10 (0) 20 2 00110041	201100 017.				
<u></u>		Sequentially list conditions,	b. Due to (or as a consequ	uence of):				
ڇَ ٦	9	any, leading to immediate ause. Enter Underlying ause (Dispass of Injury hat initiated events	240 (5) 45 45 65 150 41	301.00 01).				
Examiner	t	hat initiated events esulting in death) Last	c.					1
		osaling in doubly cast	Due to (or as a consequ	uence ot):				
ca			d					CO.
ed	-			0.00				
2	1	F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of de	livery
	'	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal		pregnancy (enecify)		Month	Day Ye
a		1 ☐ Yes 2 ☐ No	9□ Unknown	J CHIĐI	specify/			
siciar		9 Unknown		data a ta et a		00- Bid. :		
Physician		9 Unknown	anneribusing an almost to a con-		u cause diven in Part I.	238. DIG (0b)	acco use contribute to	une cause of de
by Physician/Medi	Р	9 □ Unknown art II. Other significant conditions	contributing to death but not resu	alling in the underlyin	3 3			
			contributing to death but not rest	alling in the anderlyin		1 🗆 Yes	s 2 □ No 3 □ Pt	robably 4 🗗 Úr
			contributing to death but not rest	ailing in the underlyin		24a. Was an	24b. Were at	utopsy findings av
			contributing to death but not resu	ulling in the underlyin		24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings av completion of cau
Completed by Physician			contributing to death but not resu	uling in the underlyin		24a. Was an autopsy perform	24b. Were at prior to death?	utopsy findings av
		art II. Other significant conditions		alling in the underlyin	26. Place of Dea	24a. Was an autopsy perform	24b. Were at prior to death?	utopsy findings av completion of cau
Be Completed		art II. Other significant conditions	Hospital:		26. Place of Dea	24a. Was an autopsy perform 1 Yes 2	24b. Were at prior to death?	utopsy findings av completion of cau
To Be Completed		art II. Other significant conditions 5. Was case referred to medical examiner? 1 Yes 2 No.	Hospital: Inpatient 2 28a. ate of Injury	ER/Outpatient 3☐ 28b. Time of	26. Place of Dea	24a. Was an autopsy perform 1 Yes 2	24b. Were at prior to death? 2No 1 Yes	utopsy findings av completion of cau
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edical Certification: To Be Completed	2	art II. Other significant conditions 5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigate investigate 4 Homicide 29a. Certifier 1 Certifying F	Hospital: Inpatient 2 28a. ate of Injury (Month, Day Year) on be d 28e. Place of Injury - At ho building, etc. (Specify	ER/Outpatient 3 28b. Time of Injury Mome, farm, street, factive wiedge, death occurrence.	DOA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No tory, office	24a. Was an autopsy perform 1 Yes 2 ath (Check only one) ome 5 Resider 28d. Describe how 28f. Location (Stree City or Town,	24b. Were au prior to death? 1 Yes continuous of the continuous o	utopsy findings avecompletion of cause 2 No No No No No No No North Nort
To Be Completed	2	art II. Other significant conditions 15. Was case referred to medical examiner? 1	Hospital: Inpatient 2	ER/Outpatient 3 (28b. Time of Injury M) me, farm, street, faction and/or investigat	DOA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No tory, office	24a. Was an autopsy perform 1 Yes 2 ath (Check only one one 5 Resider 28d. Describe how city or Town, and due to the carried at the time, daily performance one one one one one one one one one on	24b. Were au prior to death? 1 Yes) nce 6 Other (Spervinjury occurred set and Number or Ri State)	utopsy findings avecompletion of causes 2 No No No Northy) ural Route Number of the cause (s)
edical Certification: To Be Completed	2	art II. Other significant conditions 5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigate investigate determine 2 Accident Germine 2 Accident determine	Hospital: Inpatient 2	ER/Outpatient 3 (28b. Time of Injury M) me, farm, street, faction and/or investigat	26. Place of Dea Other: 4 \(\to \) Nursing H 28c. Injury at Work? 1 \(\to \) Yes 2 \(\to \) No tory, office ad at the time, date and place ion, in my opinion, death occur 29c. License number	24a. Was an autopsy perform 1 Yes 2 ath (Check only one) ome 5 Resider 28d. Describe how 28f. Location (Street City or Town, , and due to the carried at the time, dai	24b. Were au prior to death? 1 Yes control of the	utopsy findings avecompletion of causes 2 No recify) ural Route Numbers stated. to the cause(s) th, Day, Year)
edical Certification: To Be Completed	2	art II. Other significant conditions 15. Was case referred to medical examiner? 1	Hospital: Inpatient 2	ER/Outpatient 3 (28b. Time of Injury M) me, farm, street, fact) wledge, death occurrition and/or investigat	26. Place of Dea Other: 4 \(\triangle \) Nursing H 28c. Injury at Work? 1 \(\triangle \) Yes 2 \(\triangle \) No tory, office ed at the time, date and place ton, in my opinion, death occur	24a. Was an autopsy perform 1 Yes 2 ath (Check only one) ome 5 Resider 28d. Describe how 28f. Location (Street City or Town, , and due to the carried at the time, dai	24b. Were at prior to death? 1 Yes Once 6 Other (Spendard) The prior to death? 1 Yes Once 6 Other (Spendard) The prior to the pri	utopsy findings as completion of care is 2 No No No North Number in the care is stated. In the cause(s)
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ysici	an	1 - State Registrar Amend J 1. Decedent's Name (First, Mid	Cem #2			G827					2. Date of Dea	Day	Year	3. Time of Death
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amin		Evesham Assi				me	Bal			OI DOZ(II		40. 0001	my or Death	
eral		5. Social Security Number	6. Sex	7		last birthday)	1	r 1 Year		r 24 Hrs. Min.	8. Date of Birt (Month, Da	th v. Year)	9. Birth	place (State or Foreign
ctor		216-52-4278	XXM	2 🗆 F	55	Yrs.	IVIOTICITÀ	Days	Tiodis	1,4111.	06 1	7 48	3	MD
any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits
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	Completed	(Specify only hig Elementary/Secondary (0-12		o <i>mpleted)</i> College (1-4	4or 5+)	(Give	kind of wo DO NOT u	ork done d ise retired	during mo d)	st of work	ing			
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	ဥ	Carl Rollins									ster			
		19a, Informant's Name/Relation					•				al Route Numbe		wn, State, Zi 2121	
		Glenda Thoma 20a. Method of Disposition				Place of Dispo	sition (Nar	me of			timore	20c. Locatio		
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al r		resulting in death)			/	1 1//	614	-		17	or respiratory ar	2/		
	Ilcai Examiner	Sequentian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (o	as a consecuration as a consecur	quence of):	*C/L 6/L		-		<i>VV</i>		I	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Las tas Certificate of Death Reg. No. 1 For State Registrar Amend Item #1 per phy G827 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Charles Russell Sr. Day RUCSEL **Physician** O M JANUARY 2004 CHARLUS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BACTIMORE SECOURS BON HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days XXM 2 F Yrs. Director 251-10-7370 19 84 06 01 VA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 U.S.A. 1941 West Lexington Street deeth y Funerai 12. Was Decedent Ever in U.S. Armed Forces? ★ ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Š Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dept. of Commer permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Washington, DC 9th grade Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Russell Orin Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1941 West Lexington Street, Baltimore Md Dinell Pratt-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 1/23/04 Owings Mills, Md 21. Signature of Funeral Service License March F/H West 21215 4300 Wabash Ave, Baltimore Md as 23a Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** ACUTE IN FARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Obe to (or as a consequence of): Examiner burial-transit certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor L Dav in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pp MECLITUS 1 Yes 2 No 3 Probably 4 ☑ Unknown Completed WENT/A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospitel within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SECOUPS HOSPITAL BON BATTMORE S MILVER

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Monta, DA)

ORIGINAL

32. Aggistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Amend Item 20b per FH, G827, 01/29/04dh ertificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 10:10 A M January 19 2004 Americus Melvin Roy /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore GBMC Gilcrest Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**√**M 2□F 220-22-7788 74 04/12/1929 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 28a-f show rithen "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 X Yes 2 No Maryland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 U.S.A. 6109 Moyer Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 (2) Yes 2 No 1948 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within in and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Ordained Deacon Catholic Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn James Melvin Rov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum Betty Roy / Wife 6109 Moyer Ave., Baltimore, Maryland 212u6
ce of Disposition (Name of 01/2098)9. 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 01/29784 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. 01/26/2004 Owings Mills, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility he Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Lice 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepatocellular Corcinoma Physician MOZITUS /Medical Due to (or as a consequence of): Examiner attitis YCATS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ sion of Vital Records, icate has been sig , page 2 should b 1 🗌 Yes 2**∑**No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 2000No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 At ther (Specify) (55)3(22) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 29No şiy 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural
2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital of within 24 hours at To the Funeral D TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Linuari 9-00-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLOIN, Charles Sr Bultimore now (2/10) 32. Registrar's Simature State 31. Date filed (Month, Day, Year) Registrar

		Please I	ype or Print in B				-	_	
		For	State of Maryland	•			ental Hyg	giene	01000
		1 - State Registrar		Cer	tificate of	Death	R	leg. No. 4 UU4	4 U1266
		1. Decedent's Nama (First, Middle, Last)	0	1			2. Date of Dear Month		3. Time of Death
Physic		Victoria	Kasins	MI			Monar	Day Year	11:40 FM
/Medi Exami		4a. Facility Name (If not institution, give s	treet and number)	//	4b. City, Town, o	r Location of Death		4c. County of Deat	h
LAdilli	iei	Heritage Ger	OPSIS		Nim	JOIK V	MD	Pa/	to Co.
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Il Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	9. Birt	hplace (State or Foreign
Director		216-07-4080 10	M 20 F 88	Yrs.	Months Days	Hours Min.	Monto, Day	1910	MD.
		Usual Residence of Decedent					1	// // 4 -	
ylan		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
Mar Fed	to	MD Balta	O(D + D)	INC	Jalk				1 ☐ Yes 2 🔀 No
288 100	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	untry?
3a o		6712 Riverdrive F	heo!		212	19		USA	
ING 21213-UU35 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23s or 28s-1 show event, the Modical Expense Grant be notified at	Funeral		12. Was Decedent Ever in U.S	S. 13. V		dispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		
ter o	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 Mg No			an, Mexican, Puerto I	Rican, etc.)	Black, White	e, etc.
JS as all, o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify: Wh	ite
5-0036 72 hours af natural, or deal Exem	ed	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occup	pation		16b. Kind of Business/	Industry
CL:	Completed	(Specify only highest grade	completed)	(Give l	kind of work done OO NOT use retired	during most of workind)	ng		
within lene.	E	Elementary/Secondary (0-12) 8 years	College (1-4or 5+)	Hous	ewife		,	Own Home	:
filed w Hygier other th		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Sumame)	
	Be	Andrew Mik				Mary P	ieta		
should and Men marks	ည	19a. Informant's Name/Relationship (Ty)	no Print)	10b Mailin	Address (Street			r, City or Town, State, 2	Zin Code)
re, Maryic s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Robert Rasinski	son					re, MD. 212	
C = 4 F					sition (Name of			20c. Location - City or	
Saltimore, Dermit. Pages 1 a Department of Hez mportant: If item moy injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	metery, crem	atory or other plac	ce) Janua	ary		
Pag ment: ant:		`4 Donation 5 Dother (Specify)	HOT		ry Cemet		2004	Dundalk, Md	
Baltimol permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	00) 22	Name and Addre	ss of Facility Funeral E	Iome Of	Dundalk, P.	Α.
10 85E 8 8		(hithory	Connelle		7110 Sol	lers Point	- Road	Dundalk Md	. 21222
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	Do not ente	r the mode of dyir	ng, such as cardiac o	r respiratory arr	rest,	Approximate Interval Between
Physician		Immediate Cause (Final	1100000	A CI	RODI	4 × 15-	1550 0	- 06	Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):		N MEIN		PROMEY	
Examiner			HEMDRRY Due to (or as a consequ SEIZUR	T 1	15087	DED UN	KNOW	2 X1897 X	
	5	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		BURD				
) led /	- L	Cause. Enter Underlying Cause (Disease or infury	ASPIRA.	5100	l Vr	EU MOR	-127		
xecu and	Examiner	that initiated events consulting in death) Last	Due to (or as a consequ-	ence of):	7/12	-U MOA	///		
760, e be executed rsician and e burial-transit	alE		APHACIA						
687 ificate g physi as the	dici		1311/12/1						
	Physiclan/Medic	IF FEMALE:	20 It was automo of acomo						
BOX sath cert attendin for use	an	23b. Was decedent pregnant in the past 12 mooths?	3c. If yes, outcome of pregnar 1□Live birth 2□Fetal	death 3	Ectopic pregnancy	y		23d. Date of del Month	ivery Day Year
D. L. B dea he a	Sic	1 ☐ Yes 2 ☑ No	4 Pregnant at time of de 9 Unknown	ath 5	Other (specify)				,
I Records, P.O The law requires that the ate has been signed by the page 2 should be detached.	Phy	9 Unknown							
S, l	by	Part II. Other significant conditions cor	tributing to death but not resu	lting in the ur	derlying cause giv	en in Part I.		bacco use contribute to	7
Division of Vital Records, to a strength of Physician: The law requires to after death. Director: After this certificate has been signed in by the tuneral director, page 2 should be on the page 2.							1 🗆 Y	es 2□No 3□Pr	obably 4 Donknown
w re	Completed						24a. Was a	an 24b. Were au	topsy findings available
Heche lav	E						autops	med? death?	completion of cause of
r Vital Roystcian: The is certificate hidirector, page	C	OF Man and referred to medical						2DNo 1□Yes	2 No
Division of Vita vita Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the tuneral director;	00	25. Was case referred to medical examiner?	lospital:		o Oth	26. Place of Death			
Phys this al di	2	1 ☐ Yes 2 ♠ No 27. Manney of Death	1 Inpatient 2 L	R/Outpatien 28b. Time of	3 DOA	4 Nursing Hor		ence 6 Other (Spec	cify)
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injur Wor		ad. Describe no	ow injury occurred	
Sion tend eath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
DIVI	Ē	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		et, factory, office	1	28f. Location (Si City or Town	treet and Number or Au n, State)	iral Route Number,
DIVISION To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Ö								
To the Hospita within 24 hours To the Funeral completely filled	ca	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the tir	me, date and place, a	and due to the c	ause(s) and manner as	stated.
n 24 n 24 he F	Medical	one)	and manner stated.		estigation, in my c	philion, death occurr	od at tille tillle, d	and place, and due	(to life Cause(s)
With With Com	Σ	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (Monti	h, Day, Year)
		Carinde.	V/ala	MD	02	7/88		119 504	2
. 7	Ì	30. Name and address of person who co	maleted cause of death (Item	23a) (Tvna	Print)	., 00		11/07	
		Cainta 11	10.00 2 M	Tall al	- Ph.	Mond	marc 1	(17) 2/2	22-
6 0	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	, me	July !	· · · /	71/42	
Regis		4 4	004		, i				
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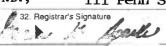
				ype or Print in i					
			1 - For Amend Item 10e p	State of Marylar	nd / Departme	ent of Health and	Mental Hygier	ne 2001	. 01267
			1 - State Registrar	,002,,01,21	Certifica	ate of Death	Reg. l	No	01201
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	V Roche			2. Date of Death Month January	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. Ci	ty, Town, or Location of Deat		4c. County of Dee	
	H		Sinai Hospital of B	altimore	Ba	Himore Cit	Ty	N/	A
	Funeral Director		213-07-2000 /	M 2□F 7. Age (In yrs.	Yrs. If Und Month	der 1 Year If Under 24 Hrs as Days Hours Min.		9. Bl	hplace (State or Foreign untry)
	pug A		Usuel Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
che	h the Marylan r 28a-f ehow r retified at	ctor	MD NA		Bo	Utimore			12 Yes 2 □ No
1 Re	death with the Maryland ms 23a or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number 21 3950 Pen	hurst Ave	10f. 7	21215	10g.	Citizen of What Co	untry?
20		ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Dec	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame Black, White	
mond 36	a o		1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 No If Yes, Give		2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	Ringt
Raym 215-0036	72 hours 'naturel' dical Ex	Completed by	15. Decedent's Edu	Year or Dates:	16a. Decedent's Us	sual Occupation	16b.	Kind of Business/	Industry
X 515	G 9	plet	(Specify only highest grade	e completed)	(Give kind of	work done during most of wo. use retired)	rking		~ 1
4	d within giene. or than	E O	G+11 GRADE	College (1-4 or 5+)	Steel	worker	16	ethelly	am Steel
<u> </u>	be filed ital Hygi od other	To Be (17. Father's Name (First, Middle, Last)			3	me (First, Middle, Maid	en Sumame)	
\$ 5	should be to the should	10	Willis Kac	ne			abeth	Hure	Y
Known +	nd 2 alth a 27 is r trau		19a. Informant's Name/Relationship (Ty	dson (niecz	196. Mailing Addre	ess (Street and Number 10 KOW RO	ural Route Number, Cit	y or Town, State,	21229
(1)			20a. Method of Disposition		Place of Disposition (A cemetery, crematory o	lame of rother place)	Date 20c.	Location - City or	Town, State
attent Baltimore	5 0		1 ☐ Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ruid Ric		24-04 6	altima	ore mo
alt alt	permit. Pag Department Important: any Injury o		21. Signature : Funeral Service Licens	3 16	22. Name	Address of Facility VO	wohnce	reene F	uneralsno
72 B	89 5 5 8		bugh	Linen	- 55	Balto. N	all Pike.	Batto.	MD 212
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Sepsis	5				10 days
	/Medical Examiner		resulting in death)	Due to (or as a consec	^				
1		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec					10 datis
	tursit	Examiner	Cause (Disease or injury	and the second second		Heart Fai	line.		in davis
Ć,	be executed sicien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	(uence of):	TCATT . CCC	acti c		10 days
760,	te be ex ysicien ie burial	cal		1					
68	rtifica ng ph as th	ledi	15.55141.5						
Вох	death certificate to attending physical for use as the E	an/h	230. Was decedent pregnant	3c. If yes, outcome of pregnation 1 Live birth 2 ☐ Feta	ancy al death 3 ⊟Ectopic	pregnancy		23d. Cate of deli	,
	The law requires that the death certificate tte has been signed by the attending physbage 2 should be detached for use as the	Completed by Physician/Media	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of c	death 5 ☐ Other ((specify)		Month	Day Year
P.0	that the deed by the detached	Ph	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlying	cause given in Part I	23e. Did tobaco	o use contribute to	the cause of death?
ds,	w requires that s been signed b should be deta	d by	Company Arter	11 Disease,		, g		2 No 3 Pro	
cor	w req	lete	Canalanuscat	5			24a. Was an	24h Were au	topsy findings available
Re	i ician: The lav certificate has rector, page 2	ш	- caralongopai	Ny .			autopsy performed	prior to death?	ompletion of cause of
tal		0	25. Was case referred to medical			26 Place of Dec	1 ☐ Yes 2 🗷(t) ath (Check only one)	No 1 ☐ Yes	2×(No
<u> </u>	ysician: is certific director.	To B	examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3 1	0.1	lome 5 ☐ Residence	6 ☐Other (Spec	rify)
0	Attending Physician: r death. ector: After this certifica		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
siol	death. ctor: Al y the fu	atic	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	al or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h- building, etc. (Specif		ory, office	28f. Location (Street City or Town, Sta		ral Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause arred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
_	o the o the omple	Mec	29b. Signature and title of certifier	and mainter states.	2	29c. License number	29d. [Date signed (Month	, Day, Year)
	- > - ō		Marine Ouilie	0.00		RFS-XXX	To	Vigini 10	20011
	7.1		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type, Print)		Jui	mary M	1004
	4		Neva A. Oulika		in Hospital	of Baltimore			
	Sta Registr		31. Date filed (Month, Dax, Year)	2. Registrar's Signa					
	TIEGISII			4	Charles Annual				

		1 - For Stata Registrar	State of Maryland	d / Depa	artment		Mental Hygi	_	01268
Physicia . /Medic	al	Deedent's Name (First, Middle, Last) Deanna B. Runde Rande Rande			4h City T	own, or Location of Dea		Day Year 17, 2004	3. Time of Death 12:30a M
Examin Funeral Director	er	Cherry Lane Nurs 5. Social Security Number 6. Sex	ing Home	ast <i>birthday)</i> Yrs.	La If Under	ure1	8. Date of Birth	Prince	Georges hplace (State or Foreign untry) Texas
within 72 hours after death with the Maryland ene. 10. "A naturel", or flems 23a or 28a-1 show he Medical Examenat he motified at	Director	10a. State 10b. County MD Prince Ge	77	.Town or Lo		Code	10	ng. Citizen of What Co	
be filed within 72 hours after death with the Manylan atal Hygiene. sol other than *naturel', or liems 23a or 28a-f show event, the Medical Examinat must be notified at	Funerai	6817 Pineway 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decede	20782 ent of Hispanic Origin? (Stry Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	United S 14. Race - Ame Black, Whit	rican Indian,
d 2 should be filed within 72 hours aff th and Mental Hygiene. 77 is marked other than "naturel", or treumatic event, the Medical Exami	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)			Occupation k done during most of wo a retired) dministrato	r	Church	Industry
should ind Mer ind Mer ind Mer ind Mer	To Be	17. Father's Name (First, Middle, Last) James Taylor Boy 19a. Informant's Name/Relationship (Ty)		T		Texie	ural Route Number,	Boyd City or Town, State, 2	Zip Code)
permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumatic ange.		Jennifer Diane Run 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 3 □ Other (Specify)	emoval from State	lace of Dispo emetery, crea	osition (Nam matory or oti	n Way, Laur e of her place) 1/20 latory at LP	/04 2	0708 20c. Location - City or altimore,	
permit. Departm Importe any inju		21. Signiture of Funeral Service Licurses 234. Part1. Enter the disease, or complishock, or heart failure. List only on	Hollar	10/2	2.Name and Simple 1040 R	Address of Facility Tribute Fu ockville Pi	neral and ke Rockvi	Cremation	Approximate
Physician Physician and Physic	icai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I ary, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	Breast uence of):					Interval Between Onset and Death
The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	⊒Ectopic pre ⊒ Other (spe			23d. Date of del Month	ivery Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	anderlying ca	use given in Part I.		24b. Were au	obably 4 DUnknown
nysicien: The law requires t his certificate has been signe I director, page 2 should be o	e Completed	25. Was case referred to medical				26. Place of De	autopsy perform 1 Yes 2	ned? death? X No 1 ☐ Yes	completion of cause of
	Certification; To B	examiner? 1 Yes 2XXIo 27. Manner of Death 1X Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At he building, etc. (Specific	28b. Time of Injury	of 28	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	reet and Number or Ru	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical Cert		sician: To the best of my knomer: On the basis of examinal and manner stated.				e, and due to the ca urred at the time, da	use(s) and manner as ite and place, and due	
Totl within Total	M	29b. Signature and title of certifier 30. Name and address of person who co	/		, Print)	License number D52261	1	3d. Date signed (Mont January 19	
Sta Registr		Dr. Alan R. Segal 31. Date filed (Month, Day, Year)	32. Registras Signa		e, Lau	rel, MD 20	708		

		1 - For State RegistraMEND ITEM #6 I	State of Ma PER FH G828 2,	ryland / Depa /04/04 J нСе	artment of He rtificate of D	ealth and M Death		iene _{g. No.} 200!	+ 0126
Physicia /Medica		1. Decedent's Name (First, Middle, Las	st)	ne.	Reaves		2. Date of Deat Month	Day Yeer	3. Time of Death
Examine		4a. Fecility Name (If not institution, give Doctor's Communi		1		nham		4c. County of Dec	
Funeral Director			7. Age	(In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 6/19/19	36 Nort	rinplace (State or Fore Jountry) th Carolin
Maryland f show	lor	Usual Residence of Decedent 10a. State 10b. County MD PRINCE	GEORGE'S	10c. City, Town or Lo		1			10d. Inside City Lir 1X Yes 2 □
h with the 23a or 28a at be notii	Funeral Director	10e. Street and Number 2213 COLUMBIA AVE			10f. Zip Code	20785	11	0g. Citizen of What C	ountry?
72 hours after death with the Maryland natural, or Items 23a or 28a-f show dieal Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	NAVY	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	panic Origin? (Spe , Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B	
within ane. then	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+ 2+	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) DERY OPERA	ring most of workir	ng	GOVERNMEN	
be fil	To Be C	17. Father's Name (First, Middle, Last) WILLIAM REAVES				8. Mother's Name MINNIE L			
d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (1 CAROLENE REAVES/V		19b. Mailir 2213	ng Address (Street an COLUMBIA	AVENUE L	ANDOVER	City or Town, State, MARYLAND	^{Zip Code)} 20785
Pages nent of ant: If it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dispo cemetery, crer AYDEN CE	natory`or other place)	1/20/		yden, NC	Town, State
Department Important: any injury conce.		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or comp	6	74	Name and Address 74 Landove	er Rd.	Landove	ns Funeral	Home
Chysician /Medical /Medical is physician and published and street the partial franchish	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a	consequence of): consequence of): consequence of): consequence of):	s throw	u 60 S1	S		
The est	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
engi pe q	Š	Part II. Other significant conditions or	ontributing to death but	not resulting in the ur	nderlying cause given	in Part I.	23a. Did tob	acco use contribute to	the cause of death
10	Completed					****	24a. Was an autopsy perform	prior to death?	utopsy findings avail completion of cause
r this certificate ral director.	lo de	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1 Hinpatient	2 ER/Outpatien	Other	26. Place of Death		nce 6 Other (Spe	cifu)
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury a Work?			v injury occurred	ony)
irs after deati	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	21	Bf. Location (Stro City or Town,	eet and Number or Ro State)	ural Route Number,
to Funeral Direction of Funera	edical	29a. Certifier 1 Certifying Phyone) 2 Medicel Exam	sician: To the best of iner: On the basis of e and manner state	xamination and/or inv	occurred at the time, restigation, in my opin	date and place, ar	nd due to the car d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
within 2.	Me	29b. Signature and title of certifier	odella		29c. License n	59 9 8	1	d. Date signed (Mont	
0		30. Name and address of person who of MUKERUIN ABL		oth (Item 23a) (Type, I				evency, "	
State Registra	-	31. Date filed (Month, Day, Year)	32. Registrar'	s Signature	4 had	5			

0 State

31. Date filed (Month, Day, Year) JAN 2 1 2004



Registrar

			For State Registrar	State of Ma	arylan		rtment tificate				P	leg. No.	/ 1111		01271
į.	Physicia	an	1. Decedent's Name (First, Middle, La Frederick Willi		,					-	2. Date of Dea Month January		2004 ^{Yee}		3. Time of Death 4:30 p M
	/Medic Examin		4a. Fecility Name (If not institution, giv		1		4b. City, 7	own, or	Location of	1	oundar.		County of Di		1.30 р
	Examin	er !	North Hampton Mand	r Health	Care	Center	Fred	erio	:k				Frede	ric	k
E.	Funeral Director		217-10-5600	ex 7. Ag	e (In yrs. I 84	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min. A	B. Date of Birth (Month, Day ugust	Year) 18,1	919 Ma	Birthplac Country 1 ryl	ce (State or Foreign ') and
	land ow	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d	. Inside City Limits
	a-f sh	ctor	Maryland Frederi	.ck		Rock	y Rid	ge							1 ☐ Yes 2 🛣 No
	or 28	Dire	10e. Street and Number				10f. Zip		. 7.0			_	zen of What	Country	1?
	sath w	sral	10028 Ebby Road	12. Was Decedent	Ever in III	S 13 V	Vac Deced	217		ain? (Speci	fy Vas or No-		S.A. 14. Race - A	merican	Indian
326	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens. is marked other than "natural; or items 23s or 28s-f show aumatic event, the Modical Examiner most be rivilled at	by Funeral Directo	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:			Yes, spec		Specify:		ify Yes or No- ican, etc.)		Black, W Specify: wh	hite, etc	2.
က်	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usua kind of wor	Occupa k done d	tion u <i>ring</i> mos	t of working	7	16b. Ki	nd of Busine	ss/Indu	stry
2	vithin ne. han	mple	Elementary/Secondary (0-12)	College (1-4or :	5+)	Heate						Beth	lehem	Ste	e1
2	filed v Hygie ther t		17. Father's Name (First, Middle, Last	<u> </u>		пеасе	I-COK	.e 01		er's Name (First, Middle,	Maiden	Sumame)	-	
au	id be ked o ic eve	To Be	Charles William						Ed	na Da	wson				
Maryland 21215-0036	shou and M is mar		19a. Informant's Name/Relationship (Туре, Print)		19b. Mailin	g Address	(Street a	nd Numbe	or Or Rural	Route Numbe	r, City o	r Town, State	a, Zip C	ode)
2	1 and 2 Health 16m 27		Cora L. Robison-	wife	20h B	10028 lace of Dispo			d Ro	cky R	idge, l		land 2		
وتو	Pages 1 nent of H unt: If ite ury or ot		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐		C	emetery, cren Lawn	natory or ot	her placi		1/14/					ryland
Baltimore,	- ETE.		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Liçe						-		les S.				
Ã	Depa impo any is		H'savacs	ORCK							Baltimo				
	Physician		23a. Part Finter the disease, or comshock, or heart failure. List only	pheating that caused one cause on each li	the death	_	er the mode		_		respiratory arr	est.		l Ir	pproximate hterval Between onset and Death
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_	uires that I signed by lid be deta		Part II. Other significant conditions	contributing to death b	out not resi	ulting in the u	nderlying ca	use give	n in Part I			bacco u			cause of death?
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	Physic this co	은	1 ☐ Yes 2/10 No			ER/Outpatien		_	4 LINU		e 5 🗌 Resid			pecify)	
on o	ding I h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	M	Bc. Injury Work	(? /es 2 □		od. Describe II	OW III JUI	y occurred		
Division of	i or Atten after deatl Director: I in by the	Certification;	3 Suicide 6 Could not t	e 280 Place of In	jury · At ho	ome, farm, str	eet, factory	, office		28	3f. Location (S City or Tow	treet an n, State	d Number or	Rural F	Route Number,
	To the Hospitei or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Ce	29a. Certifier 12 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis o and manner st	f examina	wledge, death tion and/or in	occurred a	at the tim in my op	e, date an pinion, dea	nd place, an	nd due to the o	ause(s)	and manner i place, and o	as state	ed. ne cause(s)
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6	6		30. Name and address of person who	aidi M.	0	23a) (Type,	Print)	C ,	Hov.	se 1	Arre	K	redes	rela	, MD
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	Dhuaisian	1. Decedent's Name (First, Middle, Last)				2. Date of Deeth	Dey Year	3. Time of Death
	Physician /Medical	Grace E. Smith				/ /	6 04	4 30 PM
4	Examiner	4a Fecility Name (If not institution, give str	eet end number)		4b. City, Town, or Loc	ation of Deeth	4c. County of Deati	1
		Franklin Squar	e HOSpita	2	Rosedo	210	Baltin	nore
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. le.	Months Dave		B. Date of Birth (Month, Day, Ye	er) 9. Birti	nplace (State or Foreign untry)
	Director	210-28-4615	1 2381	3 Yrs.		May 11,	1940 PA	
	pug *	Usuel Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
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)	the h	10e. Street end Number	MIIT	te Marsh		100	Citizen of What Co	untar?
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2	eath mas 23		. Was Decedent Ever in U,S.		Hispanic Origin? (Spec		nited Sta	
\	Tun itter d	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of I	en, Mexican, Puerto R	ican, etc.)	Black, White	
7	Maryland Z1Z15-UUZU d2 should be filed within 72 hours aft th and Mantal Hygiene. 77 is marked other than "natural", or traumatic evant, the Medical Expiri To Be Completed by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🖫 No	Specify:		Specify:	t-0
3	1 Z 1 Z 1 D-UUZ/ led within 72 hours a lygiene. her than "natural", on it, the Medical Exan Completed by	15. Decedent's Educat	ion	16a. Decedent's Usual Occu	pation	16b	Whi.	
- 3	piet ring	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working ad)	Pu	ublic Sch	ools
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_ 7	tal Hy tal Hy dothe	17. Father's Neme (First, Middle, Last)			18. Mother's Name	First, Middle, Maid	len Sumame)	
	Vid b Vid b Vid b Vice of	Delbert Eyer			Violet F	'ye		
	ary sho and h	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailing Address (Street	t and Number or Rurel	Route Number, Cit	y or Town, State, Z	ip Code)
	C = N -	Gary Smith/Husband		11603 Jerome	Ave, White	Marsh,	MD 21162	
	2 2 2 2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	20b. Placen	ce of Disposition (Name of netery, crematory or other pla	ice)		Location - City or T	own, State
	Page nent of nr: if	4 ☐ Donation 5 ☐ Other (Specify)	loval from State	sapeake Crema	. ال	an 21 004 - Be	eltsville	. MD
3	Dallimore, pamir. Pages 1 ar Department of Hea important: if item; any injury or other page.	21. Signature Funeral Service Licensee		22. Name and Addre	ess of Facility			
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	Physician	shock, or heart failure. List only one	cause on each line.					Interval Between Onset and Death
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	Examiner	disease or condition resulting in death) a.		s a consequence of):			1	Showis
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	requires that the death certificate be assocuted requires that the death certificate be assocuted seen signed by the attending physician and hould be detached for use as the burial-transit eted by Physician/Medical Examiner	Sequentially list conditions b	Due to (or a	s e consequence of):				
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	v requires that the death ce been signed by the attendi should be deteched for us, letted by Physiclan/	Part II. Other significent conditions contrib	outing to death but not resulti	ng in the underlying cause give	ven in Part I.	23b. Did tobeco	co use contribute	to the cause of death?
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Shirt of Child Control	en si ould					24a. Was an au		Vere autopsy findings vailable prior to
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3	vital in inclan: The certificate ractor, page Co	25. Was case referred to medical			26. Place of Death /	Check only one)	1	
2	Physician: This certific ral director.	examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2X EF	VOutpatient 3□ DOA Oth			6 □Other (Speci	ifv)
Č	ung Physician: h. After this certific funeral diractor, tion: To Be (27. Manner of Death		Bb. Time of 28c. Injury Wo		d. Describe how in		,,
Ċ	Attending For death. Sector: After by the funer Iffication:	1. Rendered 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)		Yes 2□No			
- 5	Atternation of the by t	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home	e, farm, street, factory, office	28	Location (Street	and Number or Rur	al Route Number,
Ĉ	tal or Attending P is after death. In Director: After tiled in by the funers Certification:	I tomordo	building, etc. (Specify)			City or Town, Ste	110/	
W		29a. Certifier 12 Certifying Physici	an: To the best of my knowle	dge, death occurred at the tir	ne, date and place, an	d due to the cause	(s) and manner as	stated.
1	he Hospi in 24 hou he Funer pletely fil	one)	On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurred	at the time, date a	na place, and due t	o ine cause(s)
	To the i within 2 To the I complet	29b. Signature and title of certifier	10	29c. Licens			Date signed (Month,	
	K	William and	rew Deme, M	ρ ν	23704	Ja	naary 16,	2004
	4	30. Name and address of person who comp						
		Dr William Ren	e. 9000 Fre	anklin Squa	ce Drive	Baltin	OGE . MI	21237
	State	31. Date filed (Month, Day, Year)	32. Registrer's Signatur	9 1				
	Registrar	JAN 2 1 2	004 Dener	3e) (Type, Print) Banklin Squa Banklin Squa	aked			
				/ //				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 19, 2004 **Physician** Strobe1 Norma Margery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Brighton Gardens of Towson Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 85 Baltimore, MD Director 218-10-8778 April 11, 1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Ellicott City Director MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. or items 23a 3004 N. Ridge Road 21043 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 XWidowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Medical Office permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: if Item 27 is marked other it any injury or other traumatic event, this once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margie L. Mills Edward Leister Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
57 Seminary Farm Road, Lutherville, MD 19a. Informant's Name/Relationship (Type, Print) Daughter Susan C. Tinanoff 20b. Place of Disposition (Name of Caffroll 120/20/2004)

Caffroll 1 Caffroll 20c. Location - City or Town, State 4 Hampstead, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 Line 3a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im salate Cause (Final isease or condition resulting in death) MULTIFORME GLIUBLASTOMA Physician mo /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 13315750 Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA this After thi 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and atte of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M M M O COSM (C 6 70) NC 31. Date filed (ModifA Ply. 201) 2004 32 Registrar's Signature State Registrar

		1 - For State Registrar	State of Maryland	d / Depa	artmen		•		004	0 27
Physic /Medi		1. Decedent's Name (First, Middle, La	Sterrett				2. Date of De Month	Day	Zoy	3. Time of Death
Exami		4a. Facility Name (If not institution, given Second Second Second Security Number 6. S			Ba:	Town, or Location of Deal Ltimore	s. 8. Date of Bir		unty of Death	place (State or Foreig
Director		218-78-9353 1 Usual Residence of Decedent	□ M 2 G + 36	Yrs.	Months	Days Hours Mir	1-15-	ay, Year) -1967	<u> </u>	place (State or Foreigntry)
the Marylar 28a-f ehow	Director	MD 10b. County MD 10e. Street and Number		1 time	ore	Code		10- 01		10d. Inside City Limit
23a or 3	rai Dir	17 N. Calhoun	St.		10f. Zip	.223		U.S.	of What Cou	ntry ?
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28s-f show event, the Medical Examenar must be notified at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	ľ	Was Deced If Yes, spe 1 Yes	dent of Hispanic Origin? (cify Cuban, Mexican, Pue 2 X No Specify:	Specify Yes or No rto Rican, etc.)		Race - Americ Black, White, ecify: Bla	etc.
within 72 ho ane. than *natur	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usu kind of wo DO NOT u	al Occupation rk done during most of w se retired)	orking		f Business/In	
be filed ntal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) John Thomas C.		Dom	10.5.01	18. Mother's Na	ame (First, Middle	, Maiden Sun		
s 1 and 2 should t Health and Men tem 27 ie marke other traumatic		19a. Informant's Name/Relationship (Darrin Mull (S)	Type, Print)			Street and Number or F	Rural Route Numb	er, City or To	wn, State, Zip	
Page nent o ant: If ury or		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	ometery, crer √Zio	natory or o n	ither place) $1-21-2$	2004	Balto	Co.	own, State
permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service Licer E.N. Walker	Tr. A.	22 E 1	step	d Address of Facility Bros. Fur Eutaw PL.	neral S Balto.	erv.	P.A. 1217	
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signed d be de	by	Part II. Other significant conditions of	ontributing to death but not resu	itting in the u	nderlying o	ause given in Part I.	23e. Did t 1 ☐			ne cause of death? ably 4 □Unknow
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Dir.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory	r, office	28f. Location (S City or Tot	Street and Nu wn, State)	mber or Rura	l Route Number,
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To the hwithin 2:	Me	29b. Signature and title of certifier	ut Colub	4.4	290	License number	50	29d. Date sig	ned (Month,	Day, Year) 4, 2009
18		30. Name and address of person who	2000 W. Ba	ltimo		St. Baltim				
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar sugnat	ure		made)				

		1	For State Registrar	State of M	aryland		artment of H		and M		ene 1. No. 2 (004	01275
			1. Decedent's Name (First, Middle, I	_ast)						2. Date of Death Month	Day	Yeer	3. Time of Death
	Physici: /Medic		Annie	Laura			Stroh			January		2004	3:50 p M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or				4c. County		
			Mariner Health		runde ge (In yrs. Ia		Glen B			8. Date of Birth	Anne	9 Righnal	
	Funeral Director		5. Social Security Number 216–18–0858	1 □ M 2 X F	81	Yrs.	Months Days	Hours	Min.	(Month, Day,) May 12,	(ear) 1922		ece (State or Foreign try) rland
	*		Usual Residence of Decedent							114, 12,			
	nylan how		10a. State 10b. County	A mum d o 1	10c. City,	Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2 2 No
	Ba-f	Sch		Arundel		oden				10	- 0%	Marin and Course	
	with th	Öre	10e. Street and Number	C			10f. Zip Code	1.0		109	g. Citizen of		uy r
	eath y	erai	512 Stoney Hill 11. Marital Status	12. Was Decedent	Ever in U.S	13.	211 Was Decedent of H	_	igin? (Spe	ecify Yes or No-	14. Rac	USA ce - Americ	an Indian,
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Maryland 21215-0036	turel sturel	edt	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16	6b. Kind of B	usiness/Inc	lustry
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Nar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship William H. Stro				Sacramen						
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DOT	Pages nent of int: If its iry or o		XX Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	, ;		dge Mem.		1/17	/2004	Elkrid	loe. M	m
Baltimore,	permit. Pages 1 and 2 Depertment of Health & Important: If Item 27 i eny injury or other tre		21. Signature of Funeral Service Lice		//		2. Name and Addres Hardesty	ss of Facility Fune	ral	Home, P.	Α.		
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O. Box 68	The law requires that the death certifica ate has been signed by the ettending ph page. 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pregnancy □ Other (specify)					ate of delive	ry Day Year
ds, P.	puires that n signed t uld be det	d by P	Part II. Other significant condition	s contributing to death	but not resu	lting in the u	inderlying cause giv	en in Part I	l.				e cause of death? ably 4 Dunknown
Vital Records,	sician: The law requir certificate has been si Irector, page 2 should I	Completed								24a. Was an autopsy perform	ed? □No	death?	osy findings available inpletion of cause of 2 No
Žį.	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	00	/	Check only one			
ō	Phys rthis ral di	5.	1 ☐ Yes 2 ☑ No 27. Manner i Death	1 🗆 Inpat	ient 2 🗍 E	28b. Time o	nt 3LI DOA	41,3140	-	me 5 Residen 28d. Describe hov			")
on	Attending r death. Ctor: After by the fune	tion	1 ratural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)	ay Yeer)	Injury		k? Yes 2 🔲	No				
Division	l or Atter after dea Director I in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of If	njury - At horestc. (Specify	me, farm, st	reet, factory, office			28f. Location (Stre City or Town,		ber or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the bes kaminer: On the basis and manner s	of examinat	vledge, deat ion and/or in	th occurred at the tire	ne, date ar pinion, dea	nd place, ath occurr	and due to the cau ed at the time, dat	use(s) and m te and place,	anner as st and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	cus	57/	Can	29c. Licens	e number	55/	(29	d. Date signe	d (Month,	.01
	٥		30. Name and address of person w	ho completed cause of	death (Item			, 0			1		
	ナ		Anil Chopra, M				ay, Glen	Burni	e, M	D 21061	1		
į,		ate	31. Date filed (Month, Day, Year)		trar's Signat		1						
	Regist	rar	JAN 2 1	2004	market .	19	JOOR A.	5/					

		4	State Amend Item #8	State of Marylan	d/LDepartment of Health Certificate of Dea	h and Me	ntal Hygiene	2001	01276
			Registrar 1. Decedent's Name (First, Middle, Las		Certificate of Deal		. Date of Death	Em () "	3. Time of Death
	Physicia	_	1. Decedent's Name (First, Middle, Las	Smorks =	Byrkon.	-	Month Day	2004	11:35 FM
1	/Medic		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location			County of Death	
1.0	Examin	er	Sinai Hospitai	of Baltin		more		NIA	
	Funeral	-1	5. Social Security Number 6. Se		last birthday) If Under 1 Year If Und	der 24 Hrs. 8	Date of Birth 5/13 (Month, Day, Year)	3/1921Birth	plece (State or Foreign
	Funeral Director	-	216-12-8767 1	JM 28 F 82	Yrs. Months Days Hou	IIS WIII.	3-14-0	 	1110
	p _	Ī	Usuel Residence of Decedent	10c Cit	ty, Town or Location				10d. Inside City Limits
	arylar ehow	-	10a. State 10b. County	100.01	Pollin	11/0			Yes 2□No
	Ne M	ecto	10e, Streel and Number		10f. Zip Code	DIC	10g. Citiz	en of Whel Cou	intry?
	e or	늄	1000 SILVANOV	d homes	#501 212	119	1	ISA	
	death with the Maryland ms 23€ or 28a-f ehow	era	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Speci		4. Race - Ameri Black, White	
	r Rer	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1 Tes 2 No Specific Cuban, Men			Specify: 21	nav
8	hours after turel; or Re	by	3 Widowed 4 □ Divorced	Year or Dates:	75 163 240 350			2	HCK
21215-0036	72 h 'natu	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usual Occupation (Give kind of work done during i ife. DO NOT use retired)	most of working		nd of Business/I	ndustry
2	within one.	id m	Elamentary/Sacondary (0-12)	Callege (1-4or 5+)	(KHY) OO		Pa	HO.C.	it School
	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	IVIA	18. M	lother's Name (First, Middle, Maiden	Sumame)	1
and	lid be iked o	To Be	(unk)		(u	nk)	P	MUUM	
Maryland	d 2 should be filed within 72 hours after death with the Marylan hand Mental Hygiene. It is marked other then "naturel; or liems 23s or 28s-f ehow traumette event, the Medical Examinat must be notified at	۲	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nu	umber or Rural	Route Number, City or	Town State, Z	ip Code)
Ž	and 2 ealth a m 27 ls	1	Darlene Camo	bell-candahi	r) 6301 Daddle	Driv	e Colum	ibia 1	MODIO
ore,	-I		20a. Method of Disposition		lace of Disposition (Name of cemetery, cremate or other place)	Da	te 20c. Loc	cation - City or 1	Town, State
Ē			• 4 □Donation 5 □ Other (Specif		eenmunt Crematon	y 01,20)-04 Ca	$H_{i}DO$	EILID
Baltimore	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licer		22. Name and Address of	facility VOU	ynn Core	ereru	now She
-	202 a		Muchn	Sold of the dead of the dead	th. Do not enter the mode of dying, such	h as cardiac or	respiratory arrest.	TITION	Approximate
			shock, or heart ailure. List only	one cause on each line.					Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Basilar Ar	tery Cerebrovascu	ild He	CIGEIT		2-days
	Examiner			Due to (or as a conse	queness on):				
V_		ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as a conse	quence of):				
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c					
o,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
3760	3 > 3	licai		d					
K 68	eath certifica attending ph for use as It	Physician/Med	IF FEMALE:	23c. If yes, oulcome of pregr	nancy			23d. Dale of deli	VAIV
Вох	ath cert	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet	al death 3 Ectopic pregnancy			Month	Day Year
	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown					
, P.O	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It	y Ph	Part II. Other significent conditions	contributing to death but not re	sulting in the underlying cause given in F	Part I.			the cause of death?
Records,	quires n sigr	Completed by	Hypertension				1 ☐ Yes 2 [□No 3□Pr	obably 4 Minknown
Ö	s been si	ojete				_	24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Re	The law	шо					performed?	death?	
Vital		Be C	25. Was case referred to medical examiner?			-	Check on one		
of V	Y S D	To	1 Yes 2 No				ne 5 Residence		city)
0 0		ii.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of trijury at Work? M 1 ☐ Yes		8d. Describe how injur	y occurred	
sio	Attending r death. ector: After y the fune	cati	2 Accident investigated 3 Suicide 6 Could not I	De Con Dines of Injury Al	M 1 ☐ Yes		8f. Location (Street an	d Number or Ru	ıral Route Number.
Division	or At lifter of Direct in by	i i	4 Homicide determined	building, elc. (Spec	city)		City or Town, State		
_	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical Certification:	29a. Certifier 1 Certifying P	hysician: To the best of my ki	nowledge, death occurred at the time, da	ate and place, a	nd due to lhe cause(s)	and manner as	stated.
	24 hi Fun etely	dica	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	nation and/or investigation, in my opinion	n, death occurre	ed at the time, date and	d place, and due	to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier		29c. License num			te signed (Monti	
			Hans Illay	L, DO.	RES-	000	Jai	nuary 1	+, 2004
	. 1		/		em 23a) (Type, Print)	, 0 1		Q ILIAA	ma MA
_	4		Hans Ghayee, D.O.,	Singi Hospitul	em 23a) (Type, Print) of Baltimore, 2401 l	West Beli	redere Avenu	e Daltim	uc, 1112 21215
	S	ate	31. Date filed Month Day, Yall 4	32. Registrar's Sig	паша				

		4	State of Sta		rtment of Health and M tificate of Death	lental Hygie	ne . No. 2004	01277
		_	Hegistrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia	an		Stricker		01/19/2	Day Year	10:25A M
•	/Medic Examin		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death	,	4c. County of Deat	1
	Examili	e.	North Arundel Hosp		Glen Burnie		Anne Aru	ndel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry)
	Director		219-16-3356 ^{128 M 2□ F}	79 Yrs.	World's Days Hours IIII	07/04/1	924	MD
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	eation			10d. Inside City Limits
•	shov	5						1 ☐ Yes 2. No
	288-1	Director	MD Anne Arundel 10e. Street and Number	Pasader	1 of, Zip Code	100	. Citizen of What Co	untry?
	with t	급			21122	1.5	U.S.A.	,
	s 23	eral	4303 Talbot Ct. 11. Marital Status 12. Was Deg	cedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian,
	hours after death with the Maryland turel; or Items 23a or 28a-1 show al Examiner must be inclified at	Funeral	Armed F 1 □ Never Married 2 M Married 1 1 Yes	orces? If	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
99	urs at	þ	3 Widowed 4 Divorced If Yes, G	ive l	Yes 2 M No Specify:		Specify: WY	nite
Ď.	2 hou	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupation	ing 16	b. Kind of Business/	Industry
212	hin 7	pie	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	kind of work done during most of work OO NOT use retired)	9		
2	arth.	Completed	12	Whol	lesaler		Seafood	<u> </u>
2	aveni	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	iden Sumame)	
yla	2 should be filed within 72 hours after death with the Marylan and Menhalt Hygiene and Menhalt Hygiene is marked other than "natural", or liems 23a or 28a-1 show aumatic avent, the Medical Examiner mast be inclifted at	ပ္	Charles Henry Stric		Isabel		T	Pr. O. d. l
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heatls and Menta Important: If item 27 is marked any injury or other traumatic av <u>once</u> .		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rui			ip Code)
oʻ	and fealth im 27	1/2	Barbara Stricker/Wi		Talbot Ct., Pa		AD ZIIZZ	Town, State
ŏ	ges it of H if ite		1 Burial 2 ☐ Cremation 3 ☐ Removal from	n State	sition (Name of natory or other place)		,	
<u>=</u>	tmen tmen tant:		`4 □Donation 5 □Other (Specify)	Glen Ha	ven Mem $Pk \mid 1/2$. Name and Address of Facility G .	2/04 G	Len Burn	Homo PA
Baltimore,	Deparenti Mpor any ir		21. Signature of Funeral Service Licensee		69 Riviera Dr.			
_			23a Part 1 Enter the disease or complications that					Approximate
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	() ()	7730		Interval Between Onset and Death
	mysician /Medical		disease or condition resulting in death) a.	nrmtz obb	MUCK TEM	7.57		gears
	Examiner		Puert	o (or as a consequence or):	when Do			Years
		e e	Sequentially list conditions, if any, leading to immediate	(vi as a consequence of):	Hackive Lung	ich	1 - 2 - 4	Coves
-	uted I Insit	듵	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
Ć.	exection and ial-tra	Examiner		o (or as a consequence of):				
8760,	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d					
89	tifical ng ph as th	Medi	IF FFM F					
Вох	th cer tendir r use	an/h	23b. Was decedent pregnant	utcome of pregnancy birth 2 Fetel death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
Э.	that the death certifi ed by the attending detached for use as	by Physician/Me	1 U Yes 2 U No a□ Unk		Other (specify)			
P.O.	at the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to	doath but not reculting in the u	nderlying cause given in Part I	23e. Did toba	cco use contribute to	the cause of death?
Ś,	res tha igned be de	Ď	Part II. Other significant conditions contributing to	death but not resulting in the di	idenying cause given in Functi.		2 □ No 3 Pr	
Vital Records,	w requires to been signed should be contacted.	Completed					/\	te-sy findings systable
ec	has b	du				24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
=						1 ☐ Yes 2	1 □ Yes	2 No
ŧ,	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	a Adicaio	Othor	th (Check only ofie)	2 500	-14.1
of	Physician: this certific ral director,	To.	1 Yes 20 No	Inpatient 2 ER/Outpatier e of Injury 28b. Time of	it 3 DOA 4 Nursing H	28d. Describe how	ce 6 □Other (Sperinjury occurred	city)
o	ding h. After fune	tion	Natural 5 Pending (Mo	onth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of	Attending or death. actor: Atterby the fune	fica	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, str	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru	ural Route Number,
ᅙ	al or a after i Dira	Certification;	4 Homicide determined buil	lding, etc. (Specify)		City of Town,	State)	
	Hospital 24 hours 8 Funeral I tely filled			he best of my knowledge, death	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau	ise(s) and manner as	stated.
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Diractor: After thi completely filled in by the tuneral	edical	one) and ma	anner stated.				
	To t To t	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Mont	
)					D19512		1/19	12004
١ĩ	14/		30. Name and address of person who completed ca	use of leath (Item 23a) (Type,	Print)	1 600	B	MD 21061
1	<u> </u>		31 Date filet (Month Dev Year)	1600 CRAIN + Registrar's Signature	ridans must	ob yver	DYRME,	13 01-0
	St Regist	ate rar	31. Date filed (Month, Day, Year)	A Signature	porks!			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) January 19, 2004 3:07 PM M **Physician** Struck Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Westminister Carroll Westminister Nursing & Rehab. Center 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☑ F 219-12-5149 79 July 9, Mary land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23s or 28s-1 shov other trsumatic event, the Modical Examinar must be morithed at show 1 ☐ Yes 2 ☐ No Mary land Carroll Directo Hampstead 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4420 Apt 1 Black Rock Road 21074 USA Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after then of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Fick Annie Schuman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherry Lawrence/Daughter 4604 Bucks School House Road Baltimore Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department Important: If any injury or once. Parkwood Cemetery 1/23/04 Baltimore Maryland 21. Signature of Funeral Service License Christina L. Hilton permit. Leonard J. Ruck acilityc or Helton 5305 Harford Road Baltimore Maryland 21214 hustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melashatic CANCEZ Breast GUEARD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Box 68760 Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been signal Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 1 Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Magner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospits! or Attend within 24 hours after death To the Funerel Diractor: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 20/2004 D31660 OM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westinnster STOWER AVENUE HOMAS 291 32. Registrar's Signature, 31. Date filed (Month, Day, Year) 1 2004 State Registrar

	1	State Registrar			Certifica	te of Dea		2. Date of Deat	iene g. No.	711111.	3. Time of Do
ysiciar Jedica aminei	1	Decedent's Name (First, Middle, La Anthony Mo 4a. Fecility Name (If not institution, giv.)	aurice	Solberg Der)	· · · · · · · · · · · · · · · · · · ·	y, Town, or Loca	tion of Death	January	1 0 ay	Year 2004 County of Death	9:00 A
eral ctor		392-30-2855		Age (In yrs. last i	birthday) If Und Month		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Pay, MATCH 1	Year) 9,1		Liond hplace (State or Funtry) LUS CONSI
Le notified at		Usuel Residence of Decedent 10a. State 10b. County Maryland Ha 10e. Street and Number	vrford	10c. City, To		L Air		11	On Citiz	en of What Co	10d. Inside City 1 ☐ Yes 2
Examiner must be notified at the Europea Director	runeral	1208 Mazeland Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced	ent Ever in U.S. es? One 1957 es: to 1980	13. Was Dec	21015		pecify Yes or No- O Rican, etc.)	1.	U. S. 4. Race - Amer Black, White	A.
t, the Medical Ex		15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation	16	Sa. Decedent's Us (Give kind of v life. DO NOT	vork done during		sing		d of Business/I ited St Army	Industry
Imatic event,	n n	17. Father's Name (First, Middle, Last Maurice Solberg 19a. Informant's Name/Relationship (1		18. 1	Nother's Nam	e (First, Middle, M Othy Muel ral Route Number,	ler		lip Code)
or other tra	-	Carol Solberg (C20a. Method of Disposition 1 🛛 Burial 2 🗆 Cremation 3	☐Removal from St	ate ceme	of Disposition (N tery, crematory of	lame of r other place)			20c. Loc	ation - City or 1	Town, State
ny injury DCB.	Ī	4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		AMILI				12004 <u>A</u> Jame of B			c. d 21014
6 0	+	23a. Part1. Enter the disease, or com	nplications that cau	used the death. D	610 W	. Macpha ode of dying, suc	il Rd. th as cardiac	, Bel Ai	r, I	Marylan	Approximate
cian lical iner	EX E	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or	as a consequence	o not enter the most period; se of):	ode of dying, suc	h as cardiac	, Bel Ai or respiratory arre	est,		A 21014 Approximate Interval Betwe Onset and Dec
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Department of Health and Mental Hygiene. Importent: If item 27s or 28e-f show Importent: If item 271s marked other then "netural; or Items 23s or 28e-f show any injury or other treumetic event. If a Medical Evarts at must be negliged at once.	Director		ford			Abi	ngdon					1 □ Yes 2 🔯
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7 Is m		19a. Informant's Name/Rela Sandra A. St					ailing Address <i>(Street</i> 754 Singer					
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ysician		Immediate Cause (Final	List Offig									Onset and Death
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should b	Completed										1	
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f A	읖	1 Natural 5 □ Pe 2 □ Accident in	ending vestigation		Day rear)	Inju		Yes 2 ∐ No				
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Dire Jin b	Certification;	4 🗌 Homicide	Nommied.		etc. (Specify		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, Stat	re)	,
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the the	ed	one)		and manner	stated.							1
5	2	29b. Signature and title of ce	rtifier	. Δ			29c. Licens					fonth, Day, Year)
1		Yamsl	NI	Mhu	1	Me	5 0	21809		11	4~13	2004
		30. Name and address of pe	rson who	completed cause o	f death (Item	23a) (Tv	pe, Print)					-
1		95PNASH			36 Y			monio	n no	20	093	
Stat		31. Date filed (Month, Day,)			strar's Signal		_ •->					
Stat Registra			TARI S		Mary Congress		to don't	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Man	,	epartment of H Certificate of I			ene 2004	01281
Ø,	Physicis		Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	Elizabeth 4a. Facility Name (If not institution, g	M •		Sel]	Lers	bruary	16, 2004 4c. County of Dea	16:10 PM
	Examin	er	Maryland Ge	neral Hose	sital	Baltin	nore Ci	tei		
	Funeral		Social Security Number 6.	4 THA OFF	In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	J (Month, Day,	Year) C	thplaca (State or Foreign puntry)
dec	Director		218-74-9476 Usual Residence of Decedent		07			09 17	16	VA
	death with the Maryland me 23a or 28a-f show	_	10a. State 10b. County	10	0c. City, Town					10d. Inside City Limits 1√D¥es 2 □ No
	28a-f	recto	MD NA 10e, Street and Number		Balt	imore 10f. Zip Code		10	g. Citizen of What C	
	h with	a D	1712 North Mo	unt Street		21:	217		U.S.	Α.
		Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
0000	hours after tural', or Ita	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes XXNo	Specify:		Specify:	Black
5	72 hou	eted	15. Decedent's (Specify only highest of	Education grade completed)	16a. I	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of wo	rking	16b. Kind of Business	/Industry
-612	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12) 7th grade	College (1-4or 5+)		Homemakei			House	
N	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Las			II O III C III C II		me (First, Middle, M		
yland		To E	James Dabney					Dabney		
a	d 2 sho h and 7 is m traum		19a. Informant's Name/Relationship			Mailing Address (Street:				<i>Zip Code)</i> e Md 2 1217
<u>၈</u>	s 1 and 2 should if Health and Men Itam 27 is marke other traumatic		Alethea Booze- 20a. Method of Disposition			Disposition (Name of c, crematory or other place			20c. Location - City or	
Ē	Pages ment of ant: If I		X Surial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	Hemovai nom State		us Memoria		1/22/0	4 Arbutu	s, Md
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 eny injury or other once.		21. Signature of Funeral Service Lic	Parch		22. Name and Addre March F/1 4300 Waba	ss of Facility H West ash Ave	, Balti	more Md	21215
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ROX	it the death certif by the attending tached for use a	lan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
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Division of	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		/ - At home, far (Specify)	m, street, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
γ	To the Nogpitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical C		Physician: To the best of examiner: On the basis of examiner state	xamination and					
	To the within To the comple	Med	29b. Signature and title of certifier	CIA 10	, 5	29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
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	2		30. Name and address of person when the same and address of person when the same and the same an	o completed cause of dea	th (Item 23a) (Type, Print)	-prom	Hospi	101	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	ingicul (444	
	Registi	ar	JAN	21 2004 /	10.00	N Rock	36			

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Exar Funer Direct		5. Social Security Number 6. Sec	ing Hear	SHOUL R	ity, Town, or Location of De OLL & Common Rel older 1 Year If Under 24 H hs Days Hours Mi	rs. 8. Date of Birth	g. Birthr	olace (State or Foreign
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sath with the	eral Dire	10e. Street and Number 3911 Sadie Ro		c	Zip Code 9//33		itizen of What Cour	
OUSO hours after de ural; or Item	d by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 W No If Yes, Give Year or Dates:		cedent of Hispanic Origin? specify Cuban, Mexican, Pue s 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: Bl	
Defitition of the property of	Completed	15. Decedent's Edit (Specify only highest grace) Elementary/Secondary (0-12)		life. DO NO	sual Occupation work done during most of w T use retired) Ud ENT	porking 16b. H	Kind of Business/Ind	dustry
larylarion 2 should be file and Mental Hy is marked oth aumatic event	To Be (17. Father's Name (First, Middle, Last)	Sims Jr	19h Mailing Addr	18. Mother's N Venu ess (Street and Number or I			2.41
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permit. Pages Department of Important: If it	once.	* 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Ki		and Address of Facility Vo	22.04 1.4 aughn c. Green	Chimore Re Ferrera	MD Services
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ysician: nis certifica director,	0		ospital: Inpatient 2	ER/Outpatient 3 1		eath (Check only one)		
ng Pt	atlon: T	27. Manner of Seath 1 XNatural 5 Pending 2 Accident investigation	28a. Late of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	Home 5 Residence 28d. Describe how injur	y occurred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	(y)		28f. Location (Street an City or Town, State)	
24 ho 24 ho Fune etely f	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, death occurre tion and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as sta I place, and due to	ited. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		2	9c. License number	29d. Dat	te signed (Month, D	Pay, Year)
ì		Murole Ale 30. Name and address of person who co		1 10	RES-000	JAN	WARY 1	5 2004
4		Vicole Shilkofs	Ki 600 N		St. BA	LTIMORE.	mo ai	287
S Regis	itate strar	31. Date filed (Month, Day, Year) JAN 2 1 2004	32. Registrar's Signa	ture doork	2			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** STOFBERG TANJARY Year ROBERT 6:25PM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CENTER RANDALLSTOWN HOSPITAL BALTIMORE NORTHWEST 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) Days Hours 1 M 2 □ F 86 Yrs. 216-10-0792 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rthen "natural", or Itama 23a or 28a-f show the Medical Exercite ritual be notified at 10d. Inside City Limits Director BALTIMORE 1 ☐ Yes 2 No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 CAVESDALE ROAD 21117 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then College (1-4or 5+) 5+ Elementary/Secondary (0-12) Hygiene. OWNER PHARMACY th and Mental Hygie 27 is marked other r traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NATHAN **STOFBERG** ROSE KARCHEM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a : If item 27 is SUE SINGER / DAUGHTER 2307 CAVESDALE ROAD - OWINGS MILLS, MD 21117 permit. Pages 1
Department of Hi
Important: If iter.
eny injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Number Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM, 1/20/2004 REISTERSTOWN, MD 21. Signature of Funeral Service_Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Edwara 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE CORONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending M 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature And title of certifier 29c. License number PHYSICIAN. 29d. Date signed (Month, Day, Year) D 42723. tonn 1 JANUARY 2004 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST AVVERAHALLI HARISH. 5401 OLT HOSPITAL CENTER AUVERAHALLI MD 21133. 5401 OLD COURT ROAD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 1 2004 Registrar

			1_ For	State of Marylar	nd / Depa	rtment of	Health and		-	
			Registrar		Cer	tificate of	Death	0.000	Reg. No.	0 0 0 1 4 0 0
	ysicia Medic		Decedent's Name (First, Middle, Last	Anna	5hi	nnic	C	2. Date of De Month	Day	Year 2004 11:11 A M
	amin		4a. Facility Name (If not institution, give	Α	Pato		or Location of Deat	4 4 1	4c. Count	
Fire	aval.	4	5. Social Security Number 6. Se	x 7. Age (In y/s.		If Under 1 Year		8. Date of Bir		N/A 9. Birthplace (State or Foreign
Dire	eral ctor			M 201 75	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Pa	928	9. Birthplace (State or Foreign Country)
nyland	3		10a. State 10b. County	10c. Ci	ty, Town or Loc					10d. Inside City Limits
the Ma	ctiffee	ecto	MD. N/A		BAL	TIMORE			100 Citizen of	1 ☐ Yes 2 ☐ No What Country?
n with	atte	Funeral Director	709 S. EATON STRI	EET		101. 2ip Code	2122	4	U.S	-
r deat	BE THE	Iner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. W	/as Decedent of Yes, specify Cut	Hispanic Origin? (S oan, Mexican, Puer	Specify Yes or No to Rican, etc.))- 14. Ra	ce - American Indian, ick, White, etc.
Trice 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Examin	۵	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		□Yes 2XINo				fy: WHITE
n 72 h	BOILGE	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a Deced	ent's Usual Occu rind of work done IO NOT use retire	pation a during most of wo ad)	rking	16b. Kind of B	Business/Industry
d with	IDs M	ошо	Elementary/Secondary (0-12) 7TH	College (1-4or 5+)		MAKER	,		OWN	HOME
ould be filed Mental Hygi	ic event,	To Be C	17. Father's Name (First, Middle, Last) GERMANUS HOCK				l l	me (First, Middle KLEINHE		тө)
INIAI nd 2 sh lith and 27 is m	other traumatic event,		19a. Informant's Name/Relationship (T) ANDREW SHINNICK/		19b. Mailing 358 F	Address (Stree OLCROFT	ST., BAL	TIMORE,	er, City or Town MARYLAN	, State, Zip Code) ID 21224
Datumore, M bermit. Pages 1 and 3 Department of Health Important: If Item 27	r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. I	Place of Dispos	ition (Name of atory or other pla	ice)	Date		- City or Town, State
. Pages tment of tant: If it	jury or		* 4 ☐ Donation 5 ☐ Other (Specify)	SA			JESUS 1/1			DRE, MARYLAND
DAILITION permit. Pages Department of Important: If it	eny injury once.		21. Signature of Funeral Service Licens	energo Mão	5 31 6	224 EAS	TERN AVE.	, BALTIN	MORE, MA	R & SON, INC. ARYLAND 21224
Physic /Med Exam	lical		23a. Part. Enter the disease, or complished, or heart failure. List only of the disease or condition resulting in death)	ne cause on each line.	rue !		al S y	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
(bu, te be executed ysician and	burial-transit	cal Examiner	Societies y st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
HECONDS, P.O. BOX 6870 The law requires that the death certificate I the has been signed by the atlending physis	use as th	Physician/Medica	IE FEMALE:	d	al death 3 1	Ectopic pregnand Other <i>(specify)</i> _	cy			ate of delivery onth Day Year
uires tha	99	ρ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	- · · ·	ven in Part I.	T	obacco use cont Yes 2 □ No	tribute to the cause of death?
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Of VICEL P Physician: Th this certificate	5	Be	25. Was case referred to medical examiner?	Hospital:		Ot	/	ath (Check only o		
P P Sile	70	lon: To	27. Manner of Death 1. Matural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	iry at	fome 5 Resident	dence 6 Oth	
UIVISION OT I or Attending Phy after death. Director: After this	completely filled in by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)]Yes 2⊡No	28f. Location (S City or Tox	Street and Numb vn. State)	per or Rural Route Number,
UNISING To the Hospital or Attend within 24 hours after death To the Funeral Director:	tely filled	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the t estigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
o the	omple	Me	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signe	d (Month, Day, Year)
- > F			· mg	y mo		10	5539	1	Janua	VV 16. 2004
	0		30. Name and address of person who or	ompleted cause of death (Iter	п 23a) (Туре, F A ver)		saltin	1000	Mary	14 16, 2004
Re	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa		4			1	1-11-11

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan		artmen rtificate				Re	g. No.20	04	01286
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Smith						2. Date of Deatl Month	Day	Year 200	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)	PITAL	R	.050	Location of	10		4c. County	11 1	maro
	Funeral Director		210-24-8462	x	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth Month, Day 0/2/1928	Year)	9. Birth Cot Mar	place (State or Foreign Intry) yland
	show	ō	Usual Residence of Decedent 10a. State 10b. County MD Baltimo:		by, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2, ☐ No
	ith the N or 28a-f	Director	10e. Street and Number	ie C	Overlea	10f. Zip				10	ng. Citizen of	What Cot	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rutilised at once.	by Funeral	504 Dale Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)	Bla		
Baltimore, Maryland 21215-0036	within 72 hour ene. than "natural he Medical Ex	Completed b	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	dent's Usua kind of wor DO NOT us	il Occupa rk done di se retired)	tion uring most	of workin	g	16b. Kind of B	usiness/l	
yland 2	Mental Hygie Rental Hygie arked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last) John L. Smith		1			Mary	у В.	(First, Middle, N	faiden Suman	ne)	
Mar	nd 2 sh alth and 27 Is m ir traum		19a. Informant's Name/Relationship (7) Susan Smith/Daugl		7	-				Route Number, nore, Ma			
ore,	iges 1 a at of Hea if item or othe		20a. Method of Disposition 12 Burial 2 Cremation 3	Removal from State	Place of Dispo	natory or of	ther place		Da		20c. Location		
Baltin	permit. Pa Departmer Important any injury		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Porteral Service Licent			. Name an	d Address	s of Facility			pel Fu	nera	Maryland 1 Home Inc. 21206
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	116	AK	7.		11476			RURIAL HAY
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8760,	ate be executed hysician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a conseq	juence of):								
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on of	ding Phys h. After this funeral di	tlon; To	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		8c. Injury Work		28	e 5 🗌 Resider Bd. Describe hor			iry)
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	To the Hospital within 24 hours a To the Funeral I completely filled	edical C		vsician: To the best of my kno iner: On the basis of examina and manner stated.									
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	13		30. Name and address of person who co	ompleted cause of death (Item		Print)	wase	PC.	/R R	oitin	rofe N	C (1)	1237
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature And	all I	-		- 1				

				1 - For State Registrar	State of Maryla	and / Depa	artmen	it of ⊢	lealth and N	Mental Hyg		004	01287
		Physic /Medi		1. Decedent's Name (First, Middle, Last Angela Julia Ste						2. Date of Dea Month January	Day	04 Year	3. Time of Death 12:30P M
		Exami		4a. Facility Name (If not institution, give Joseph Richey Ho				Town, or	Location of Death ore		4c. Cour	ity of Death A	
	÷	Funeral Director		5. Social Security Number 6. Se. 218–18–9466	7. Age (In y	rrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 3/21/1	924	9. Birthp Cour Mar	place (State or Foreign htry) yland
<		Maryland -f show	tor	10a. State 10b. County FL Pine11.		City, Town or Lo		cks .	Beach			1	Od. fnside City Limits
230		h with the 3a or 28a	Funeral Director	10e. Street and Number 2308 lst Indian	RocksBeach		10f. Zip			1	0g. Citizen o	f What Cour	ntry?
	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show say injury or other traumatic event, the Medical Evantural master must be invitited at SARE.	þ	11. Marital Status 1 Never Married 2 Married 3 Married 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Deced Yes, spec		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	ВІ	ace - Americ ack, White, ify: White	etc.
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1230	Maryland 21215-0036	uld be filed v Aental Hygie rked other t tic event, In	To Be Co	17. Father's Name (First, Middle, Last) James Millionie		wali	ress		18. Mother's Name		Restu Maiden Suma Onatos		
		l and 2 sho Health and M Im 27 is ma Her traums		19a. Informant's Name/Relationship (Ty Kathleen Burns		122	Hart	wood	Drive Wo	odstock	, Geor	gia 30)189
hoh	altimore,	iit. Pages i artment of h ortant: If ite injury or ot i.		20a. Method of Disposition 1 Burial 2 Stremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensi	emoval from State B		ish.	ther place Crem	atory 1/1	.7/04	Laure	l, Mar	
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DHMH 16 Rev 6/95

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Physici /Medio		Naomi Frances	Taul			# 0'h T	L services of Dog		y LO, ZU		10:30a м
Examin	er	4a. Facility Name (If not institution, given Franklin Square				4b. City, Town, or Roseda]		atn	Balti		
Funeral Director		5. Social Security Number 6.5	Sex I□M XXXF		rs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		in 1919	9. Birthplace Country) Mary	e (State or Foreign
LL OF		Usual Residence of Decedent		100	City Town and a					104	Inside City Limits
anylar show	2	MD Baltimor	e	100.	Rosed					1	1 ☐ Yes 2√2 No
the N	ect	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country?	?
3a or		7925 32nd Street				21237			USA		
ite, intally judical ZTZ 13-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural; or itema 23e or 28e-1 show other traumatic event. Ita Medical Erani ret must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	Armed F	cedent Ever in orces? 200 No ive	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2000 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	14. Race Black Specify:	- American I K, White, etc. White	
2 hou	ted	15. Decedent's E (Specify only highest gr)	16a. Dece	ient's Usual Occupa	ation	orkina	16b. Kind of Bus	siness/Indust	try
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C 0 - 6	-	19a. Informant's Name/Relationship Albert C. Tauber		lusband		ng Address (Street a		Rural Route Numbersedale Ma			de)
S 1 and of Health tram 27 other tr		20a. Method of Disposition	35		b. Place of Dispo cemetery, crer	sition (Name of natory or other place	θ)	Date	20c. Location - 0	City or Town,	State
Pages Thent of the		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemoval from	N	Metro Cr	emetory	1/2	21/2004	Catons	sville	MD
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service Liqu) ()	tas	/	Name and Address	, CA	rach/Rose we Rosed			
	1	231 Fart1. Enter the disease, or con shock, or heart failure. List only	plications that	caused the deach line.	eath. Do not ent			ac or respiratory a	rrest	Ap	proximate erval Between aset and Death
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/Medical Examiner		resolung in death)	Doge to	(or as a con	sequence of):	11/0/	reció	RILL			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transf	Medical Ce		miner: On the			n occurred at the tim vestigation, in my of					
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			for State Registrar	• •	Department of Health and M Certificate of Death	-	
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Control of the state of	street and number)	TINKER = 4b. City, Town, or Location of Death Rait Word	2. Date of Death	Day 2 Year 19 19 PM 14. County of Death NA
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bii M 2□F	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 3-4-42	9. Birthplace (State or Foreign Country) NA
	th the Maryland or 28a-f show	Director	10a. State 10b. County Md. NA 10e. Street and Number	10c. City, Tow Ba.	n or Location Ltimore 10f. Zip Code	10g. C	10d. Inside City Limits 1 X Yes 2 □ No Citizen of What Country?
920	d within 72 hours after deeth with the Maryland jiene. r then "netural", or Itams 23a or 28e-f show the Medical Esactinat must be rodified at	by Funerai	272 Mason Ct. 11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 (☑Yes 2 ☐ No If Yes, Give Year or Dates:	21231 13. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	d within giene. ir then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Chief of Operation	A.	Kind of Business/Industry Hoffman Awming Co.
ıryland	should be nd Mental marked o	To Be	Morgan 19a. Informant's Name/Relationship (Type	Tinker	Tina . Mailing Address (Street and Number or Rura		Moss
	ges 1 and 2 of Health a If item 27 is		Donna Hoffman 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re	Employer 20b. Place o	405 N. Paca Street, B	altimore,	
Baltimore,	permit. Peg Department Important: I any injury o once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Garris	son Forest Vet 1-22 22. Name and Address of Facility March F.H. East		vings Mills, Md. ore, Md. 21202 orth Ave.
	be executed /Medical /Medical /Medical polyal-transit	Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	tension		Approximate Interval Between Onset and Death VEALS
). Box 68760,	ath certificate attending phys for use as the	Physician/Medical Ex	IE FEMALE:	Due to (or as a consequence 3c. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day Year
rds, P.O.	quires that the de n signed by the a	by	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed?	
of Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	ospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	
Division	Attending death. octor: After y the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		njury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju 28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
	Hospite 4 hours Funere	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of my knowledge er: On the basis of examination an anomanner stated	e, death occurred at the time, date and place, a dor investigation, in my opinion, death occurred	and due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the To the Complete	M	29b. Signature and title of certifier	(DO DO	29c. License number 86552		ate signed (Month, Day, Year)
	Sta	te	30. Name and address of person who con the control of the control	mp cause of death (Item 23a)	(Type, Print)	5+ Bal	to 1MD 21287
	Registr	ar	JAN & T	LUUT LANGUE .	Charles 1		

State Registrar **DHMH 16 Rev 6/95**

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 21

32. Registrar's Signature,

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

KRIS M., SHEKITKA MD. DEFT, OF PATHOLOGY, ST. AGNES HISPITAL, BALTIMORE, MD

00037359

29d. Date signed (Month, Day, Year)

JANUARY 20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year JOHN, William Taylon 16 2004 3:2340 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Death BAIT MORE BAIT, MORE VELERANS APMINITRATION N/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Days 1**X** M 2□ F Mary Land 212-26-6217 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1105 Newcomb Way 21205 u. s. A. Race - American Indian, Black, White, etc. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Folces, 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1951-1955 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: Specify. 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Cab Driver Sun 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John P. Taylor Elizabeth Mullagen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lakeview Circle, Apt F1, Ridley Park, Pa. 19078 Kelly Taylor (Daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Chapel Church Cem. 1/19/2004 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumetic event, the Medical Examiner must be retired at

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, paga 2 should be detached it

Hospital or Attending Physician: The lew requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760,

25					Orisot aris coas.
Immediate Ceuse (Final disease or condition	PNEUMONI	Δ			
resulting in death)	Due to (or as a consequence	of):		
_	b. A JUIT REC	P.RAIGRY	PISTREW S	YNDROME	
Sequentially list conditions,		or as e consequence		3	
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	,				
Ceuse (Disease or injury that initieted events resulting in death) Last	Due to (or as a consequence of	of):		
Toolking in doubly bush					1
_	d		·		
Part II. Other significant conditions or	ontributing to death but not re	sulting in the underlyin	g ceuse given in Part I.	23b. Did tobacco use con 1 ☐ Yes 2 ☐ No	ntribute to the cause of death? 3 Probably 4 □ Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1□Yes 2ENo	1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1☐ Yes 2☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	ome, farm, street, fac	tory, office	28f. Location (Street and Numb City or Town, Stete)	er or Rurel Route Number,

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

who completed cause of deeth (Item 23e) (Type, Print)

BAITIMORE MY 21201 10 N. GIREENE ST

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signeture

JAN 2 1 2004

			State of Maryland / Dep 1- State Amend Item 26 per Verb., G827,01/21/0/db	artment of Health and Me httificate of Death	ental Hygiene Reg. No.	2004 01293
	Dhomisi	4	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physicia /Medic		Nelson Martin Tucker		01/14/20	04 11:22 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
			North Arundel Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Glen Burnie If Under 1 Year If Under 24 Hrs.	B. Date of Birth	nne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1. Security Number 81 Yrs.	Months Days Hours Min.	(Month, Day, Year) 08/28/19	9. Birthplace (State or Foreign Country) MD
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Manyl f sho	ō	MD Anne Arundel Pasade	ena		1 ☐ Yes 2 🛣 No
	28a	rec	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
	3a of		8311 Loblolly Lane	21122	U.	S.A.
	be filed within 72 hours after death with the Maryland hal Hygiene. nd other than "natural", or Items 23a or 28a-f show event, Ite Medical Ezamirar must be notified at	Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 □ Never Married 2 Married 1 Mayes 2 □ No 1942 -	1 ☐ Yes 2 No Specify:		Specify:
8	hour tural	ed b	1944	edent's Usual Occupation a kind of work done during most of workin	16b. Ki	White ind of Business/Industry
21215-0036	n na na Medis	Completed	(Specify only highest grade completed) (Givilife. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workin DO NOT use retired)	g	,
212	filed within Hygiene.	E		ern Owner	Se	lf-Employed
Maryland	be filed ital Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	Sumame)
yla		၉	Nelson Martin Rodey	Alica J		Town Class Tie Onde)
Mai	2 6 9 2			ing Address <i>(Street and Number or Rura)</i> 309 Loblolly Lan		
	s 1 and 2 if Health itam 27 I		20a Method of Disposition 20b. Place of Disp	osition (Name of Da		ocation - City or Town, State
l O L	Pages nent of int: If it iry or o		1 Burial 2 DN Cremation 3 LIHemoval from State	matory or other place) W Crematory 01/1	6/04 Bal	timore.MD
Baltimore,	그 된 원 중 .	- 4				uneral Home, PA
m	Depa Impo any ir		The / Som	169 Riviera Dr.,		
			23a. Pert1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ey DISEASE		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	40		
		7	Sequentially list conditions, if any, leading to immediate b. The state of the sequence of the	(1-)		
)—	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	LiTUS		
o,	en and	Еха	resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physicien and the burial-transit	dical	d			
9	entific ding p	(e)	IF FEMALE: 23c. If yes, outcome of pregnancy			004 0-4-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-
Вох	death certific e attending p id for use as i	Physician/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
0	0 0	isku	1 Yes 2 No 9 Unknown 9 Unknown			1
۳,	es that igned b be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
rd	v require been sig should b	ed k	BYHODER CHMCER		1 Tes 2	□ No 3 □ Probably 4 □ Unknown
Records,	2 5 2	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
= =		Con			performed? 1 ☐ Yes 2 No	death? 1 Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		_
of	Phys	- To	27. Manner of Death 28a, Date of Injury 28b, Time	INT 3 DOA 4 Nursing Hom	e 500 Besidence 6 3d. Describe how injur	
O	iding Ph th. : After th s funeral	ition	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,
Division	l or Attendi after death. Director: A I i∩ by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (Street an City or Town, State	nd Number or Rural Route Number,
ā	ital or rs afte al Dir ed in	Cert	building, etc. (openly)			/
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)			
	the the	Med	29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)
	F ≯ F 8		B all I ho have	191141	//	116/04
7			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		110/2
_			Dominick J. MEMOLIMS 1406	S. CRAIN HIGHWA	GLENBY	1906 MD 31061
15,	Sta Registi		31. Date filed (Month, Day, Year) JAN 21 2004 32. registrar's Signature	books		5/2 = 5/

		For State Registrar	State of	Mary		-	tment o			and M	ental Hyg	jiene	200			294
Physicia		1. Decedent's Name (First, Middle, L.		L.	Washi	ngt	on				2. Date of Dea Month	Day	Ye		3. Time	of Death
/Medica Examine		4a. Facility Name (If not institution, gi	ve street and numb		ital	4	lb. City, To	wn, or i	Location o	of Death Baltim	nore	4c.	County of E	eath N/	4	· · · · · ·
Funeral Director		219-03-4296	Sex 7. 1.2 X M 2.□ F	. Age (li	n yrs. last birthi 83 Yr		If Under 1 Y Months D	ear ays	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day Jul 14	1920	9.	Birthp	lace (Sta Irginia	te or Foreign
Maryland H show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10	Oc. City, Town	or Loca	tion	Ва	ltimore					1		City Limits
h with the	al Director	10e. Street and Number 2711 Spelman Road #	B1				10f. Zip Co	de	2122	25		l0g. Citi	zen of Wha	.S.A		,
ING 21213-UU36 be filed within 72 hours after deeth with the Maryland tal Hygiene. d other then "natural" or items 23s or 28e-f show event, its Medical Exercical medical	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Deced Armed Forc 1 XYes 2 If Yes, Give Year or Date	es?	or in U.S.		s Decedent es, specify Yes 2		panic Original Description (Control of Control gin? (Spe , Puerto l	ocify Yes or No- Rican, etc.)		14. Race - A Black, V Specify:	/hite,			
C Z1Z15-0036 filed within 72 hours at Hygiene. other then "natural, or ent, tre Medical Exert	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4	lor 5+)	16a. D	Deceder Give kir life. DC	nt's Usual Ond of work of NOT use r	lone du etired)	tion uring most mploye		ng	16b. Ki	nd of Busine Cons			
	To Be C	17. Father's Name (First, Middle, Las John V	t) Vashington						18. Mothe	r's Name	(First, Middle, Annie		Sumame) shington			
		19a. Informant's Name/Relationship Gertrude Washington				244	3 Dorto	n Co		timore	I Route Numbe , Maryland	2123	0			
Pages 1 Pages		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Spec	ify)		20b. Place of D cemetery,	Met	ro Crem	ator	y	(01/23/04		Cation - City			
Dalt permit. Depart Import any inji		21. Signature of Funeral Service Lice	es H				130	p Br 0 Eu	others taw Pla	Funerace Ba	al Home P. altimore, M	212	217			
Physician /Medical Examiner		23a. Part1. Enter the disease, or our shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (100	onsequence of	7	h fari			cardiac o	r respiratory arr	est,			Approxir Interval I Onset ar	Between
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.U. BOX 68/6U, the death certificate be executed by the attending physicien and ached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	h 2 [ntattim	Fetal death		ctopic pregn other (specif					2	23d. Date of Month		ry Day	Year
S es the	ρ	Part II. Other significant conditions	contributing to dea	th but n	ot resulting in the	he unde	erlying caus	e giver	n in Part I.		23e. Did to		se contribut			of death?
The lay	Completed										24a. Was a autops perform	y	24b. Were prior death	to con	sy findin apletion o	gs available if cause of
Or VITA Physicien: r this certific	Be	25. Was case referred to medical examiner?	Hospital:					Other	4		Check only or			_		
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To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place o	f Injury , etc. (- At home, farm Specify)	n, street					28f. Location (Si City or Town	reet and n, State)	d Number or)	Rural	Route N	umber,
UIV To the Hospitel or A within 24 hours after To the Funerel Director Completely filled in b.	edical C	29a. Certifier (Check only one) Certifying P	hysician: To the b miner: On the bas and manne	is of ex	amination and/o	death or	ccurred at the stigation, in	he time my opi	o, date and nion, deat	d place, a	and due to the co	ause(s) ate and	and manner place, and	as sta	ated. the caus	Θ(s)
To the To the Company of the Company	Ž	29b. Signature and title of certifier	Mn						number	7		-	e signed (M			
3		30 Name and address of person who	STOKET	10	24 %	ype, Pri			rin	4	in Be	1101	wee /	1	2121	×.
Stat Registra		31. Date filed (Month, Day, Year)	2 1 2004	pistra	Signature	مار	Sie	R)			1					

*		1 - For State Registrar 1. Decedent's Name (First, Middle, La	ist)		C	ertificat	e of L	Death		Re 2. Date of Death	g. No.	104	3. Time of Death
hysici /Medio		,		lvin	Wyat	t					n 97, 200		3. Time of Death 12:30 P.M
Examir	er	4a. Fecility Name (If not institution, giv	3727 Bell Av			4b. City,	Town, or	Location o	Baltim	ore	4c. County	of Death	/A
uneral rector		219-20-3003	Sex I∐XM 2□F		3 Yrs.	y) If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birth	⁷ 19 30	9. Birthi Cou	plece (State or Forei Wirginia
a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. C	ity, Town or	Location	Ва	altimore					10d. Inside City Limi
3e or 28	I Direc	10e. Street and Number 3727 Belle Ave				10f. Zig	Code	212	15	10	g. Citizen of	What Coul	Ary?
id other than "neturel", or iteme 23e or 28erf ehow evant, the Medical Examiner must be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Nes 2 If Yes, Give Year or Dates:	? No 1	948 949	3. Was Dece If Yes, spe	v	spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. Black
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s marked other th umatic event, the	To Be C	17. Father's Name (First, Middle, Last,) n Wyatt					18. Mother	r's Name	(First, Middle M Ru	aiden Suman th Wyatt	10)	
item 27 is marks other traumatic		19a. Informant's Name/Relationship (Crista Bell Wyatt Wife	Турө, Print)		19b. Ma	iling Address 3727 Be	(Street a	and Number Baltimo	r or Rural ore, Ma	Route Number aryland 212	City or Town,	State, Zip	Code)
nt: If item iry or othe		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)			cemetery, ci	position (Nai ematory or o Forest Ve	ther place	s Cemet	ery (01/26/04	Oc. Location - Owing		own, State , Maryland
important: If any injury or one		21. Signature of Fureral Service Licer	1800 En //			22. Name ar	d Addres Step E 300 E	s of Facility Brothers utaw Pla	Funerace Ba	al Home P./ altimore, M.D.	A. 21217		
lysicie ne bu	ical Ex	23a. Aut. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		CAR, s a consec	DIAC quence of):	Iυ							Interval Between Onset and Death
y the attending phy iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	al death 3	□Ectopic pr □ Other (sp					23d. Dat Mo	e of delive	ry Day Year
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tor: After the funera	Certification:	27. Manney of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		iry iy Year)	28b. Time Injury	of 2	8c. Injury Work: 1 🗆 Y	at ? ′es 2 □ N		ld. Describe how	injury occurr	ed	
Hed in by		4 Homicide determined	building, et	ic. (Specii	(y)				7	3f. Location (Stre City or Town,	State)		
5 E	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best niner: On the basis o and manner st	r examina	owledge, dea ition and/or i	nvestigation,	at the time in my opi	e, date and inion, death	place, an occurred	d due to the cau d at the time, date	se(s) and mai and place, a	nner as stand and due to	ated. the cause(s)
Slate	Š [29b. Signature and title of certifier	.2			290	. License				. Date signed	(Month, L	Day, Year)
To the Funerel Director: Attenticompletely filled in by the funera		I Shu TEN	relius 1	(11)			Doc	349	52	-	1/29/	2004	4

Physici		1. Decedent's Name (First, Middle, Last,	FR DVR G82	21 1/21/1	U4 Jn	tificate of l		2	. Date of Deat Month	h Day	Year	3. Time of Death
/Medi		Pearl L. Willia	ams					J	anuary			11:30 P
Examir		4a. Fecility Name (If not institution, give				4b. City, Town, or		f Death		4c. County		
		Shady Grove Adve				Rockvil If Under 1 Year	1e	M Wre la	Davis of Blists	Mont	gome	
Funeral Director		5. Social Security Number 6. Security Number 224-32-0725	x	Age (In yrs. la	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, ept. 13	3, 1904	9. Birthi Cou Vi	olece (Stete or Foreigntry) rginia
Mo w		10a. State 10b. County		10c. City,	, Town or Lo	cation					T	10d. Inside City Limit
f Health and Mental Hygiene. Item 27 ie marked other than "natural", or Itama 23a or 28e-f show Item 27 ie marked other than "natural", or Itama De notified at	tor	Maryland Montgome	ery	Gai	thersl	ourg						1 √ Yes 2 □ N
or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
23a	rai	7425 Kilcreggan To				20879				U.S.		
Itams Diet. D	une	11. Marital Status	12. Was Decede	es?	3. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig an, Mexican	jin? (Specit , Puerto Ric	fy Yes or No- can, etc.)		ck, White,	can Indian, etc.
5 1	by Funeral	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2: If Yes, Give Year or Date			1 ☐ Yes 2 🛱 No	Specify:			Specif	y: Wh	ite
atura	ted	15. Decedent's Edu	ucation		16a. Dece	dent's Usual Occupa	ation	a f a adula a		16b. Kind of B		
Medi	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done of DO NOT use retired	during most d)	of working				
Hygien other th	Completed	6			Ba	akers Ass				Resta		t
d oth	Be (17. Father's Name (First, Middle, Last)							First, Middle, A	Aaiden Suman	ne)	
and Mental I s marked of umatic eve	ဥ	Charles W. Willia						nown		0: T	O	0.11
le m		19a. Informant's Name/Relationship (T)				ng Address (Street a						
Health a sm 27 le		Earl Shipley (Ne	pnew)	20b. Pla	ace of Dispo	Kilcregg	1	Dat		20c. Location		
nent of I int: If ite iry or o		1 🔀 Burial 2 □ Cremation 3 □ F	Removal from Sta	ate ce	metery, crer	natory or other plac	1	1 /20				
		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signifure of Funeral Service License	-	Mt.	22	sant Ceme . Name and Addres	ss of Facility	,		Loudou	ın, V	A
Departr Import any inji		Dunie 2	Alm	-		Colonial 201 Edwar	Funer.	al Ho	me d NE	Leeshu	ro.	VΔ
	m	23a. Pert1. Enter the disease, or compi shock, or heart failure. List only o	lications that cau	ised the death.							18,	Approximate
ıysician		Immediate Cause (Final	ne cause on eac	ine.	PIE	SOTA	1 0) . L E .	cocaro.	Α		Onset and Death
Medical		disease or condition resulting in death)	a. Due to (or	as a consequ		ACCO	_ ,	loce		15	-	
kaminer				THE R. LEWIS CO., LANSING	_							
		Convention list conditions	h		3.25	515						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequ		515						
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oian and urial-transit	i Exar iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	ence of):	3515						
ysician and le buriat-tra	cai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		ence of):	313						
ysician and le buriat-tra	cai	IF FEMALE:	Due to (or	as a consequ	ence of):	2513				23d Da	ite of deliv	en.
ttending physician and or use as the burial-train	cai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or d	as a consequ	ence of): ence of): ency death 3[Dectopic pregnancy	,			1	ite of deliv	ery Day Year
tending physician and or use as the burial-trans	cai	IF FEMALE: 23b. Was decedent pregnant	Due to (or d	eme of pregnar h 2 ☐ Fetel	ence of): ence of): ency death 3[,			1		
tending physician and or use as the burial-trai	cai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	Due to (or d	me of pregnar h 2 ∐Fetel nt at time of de	ence of): ence of): ncy death 3[ath 5[Ectopic pregnancy			23e. Did tot	Mo	onth	
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ate has been signed by the attending physician and page 2 should be detached for use as the burial-tra	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or d	ome of pregnant 2 February English 2 February Engli	ence of): ence of): ncy death 3 [ath 5 [death 5 [ath Ectopic pregnancy Other (specify) Inderlying cause give At 3 DOA Other 28c. Injun Worl M 1	en in Part I. 26. Place er: 4 □ Nur	rsing Home 28	24a. Was an autops perform 1 Yes 2 Check only on 5 Reside d. Describe ho	Moderate American Moderate Ame	tribute to t 3 Prof Were autoprior to co death? 1 Yes	he cause of death? bably 4 □Unknow opsy findings availab impletion of cause of 28 No	
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24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and steing filed in by the funeral director, page 2 should be detached for use as the burial-trainers.	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Due to (or d	ome of pregnar h 2 Fetel ht at time of de m th but not resu patient 2 Elnjury Day Year) f Injury - At hord, etc. (Specify, est of my know is of examination	ence of): ence of): ency death 3 [lath 5 [litting in the understand of the content of the c	DEctopic pregnancy Other (specify) Inderlying cause give At 3 DOA Cth 28c. Injun Worl M 1 DOA reet, factory, office	26. Place er: 4 □ Nur y at k? Yes 2 □ N	rsing Home 28 No 28 d place, and	24a. Was an autops perform 1 Yes 2 Check only on 9 5 Reside d. Describe ho	Moderate of the second of the	tribute to t 3 Prol Were auto prior to codeath? 1 Yes her (Special red)	Day Year he cause of death? bably 4 □Unknow ppsy findings availab impletion of cause of 2 □ No fy) al Route Number,
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24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and steing filed in by the funeral director, page 2 should be detached for use as the burial-trainers.	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) 1 Certifying Phylogole	Due to (or d	ome of pregnar h 2 Fetel ht at time of de m th but not resu patient 2 Elnjury Day Year) f Injury - At hord, etc. (Specify, est of my know is of examination	ence of): ence of): ency death 3 [lath 5 [litting in the understand of the content of the c	Dectopic pregnancy Other (specify) Inderlying cause give At 3 DOA Cth 28c. Injun Worl M 1 Creet, factory, office th occurred at the tin vestigation, in my office 29c. Licensi	26. Place er: 4 \(\text{Nu} \) yat k? Yes 2 \(\text{N} \) me, date and pinion, deat	28 No 28 d place, and the occurred	24a. Was an autops perform 1 Yes 2 Check only on 9 5 Reside d. Describe ho City or Town due to the call at the time, da 2	mad? 24b. 24b. pance 6 Othow injury occur reet and Numb, , State) ause(s) and mate and place,	anner as s and due to ded (Month,	Day Year he cause of death? bably 4 □Unknow ppsy findings availab impletion of cause of 2 □ No fy) al Route Number, stated. o the cause(s) Day, Year)
ate has been signed by the attending physician and page 2 should be detached for use as the burial-tra	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or d	ome of pregnar h 2 Fetel at at time of dem the but not resu the but not resu the but not resu finjury Day Year) finjury At hord, etc. (Specify, est of my know is of examination stated.	ence of): ence of): ency death 3 [lating in the understand of t	DEctopic pregnancy Other (specify) Int 3 DOA The 28c. Injuny M 1 Preet, factory, office The occurred at the tiny vestigation, in my o	en in Part I. 26. Place er: 4 □ Nui y at k? Yes 2 □ N	28 No 28 d place, and the occurred	24a. Was an autops perform 1 Yes 2 Check only on 9 5 Reside d. Describe ho City or Town due to the call at the time, da 2	macco use confines 2 No ny nad? Planta No nece 6 Oth ow injury occur reet and Numb n, State) ause(s) and mate and place, 9d. Date signe	anner as s and due to ded (Month,	Day Year he cause of death? bably 4 □Unknow ppsy findings availab impletion of cause of 2 □ No fy) al Route Number, stated. o the cause(s) Day, Year)

Piease Type or Print in Biack indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dev **Physician** 11:50 am BURTON WECHSLER January 18, 2004 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) 4 Indiana 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days XXM 2□ F Months 303-24-6921 Yrs. 79 Director August 22, Usual Residence of Decedent parmit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental hygiene. Important: If Item 27 is marked other than "naturel", or Neme 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits No 2□ No Funeral Director N/A N/A Washington, DC 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 2914 Garfield Street, N.W. 20008 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√√No Specify: Specify: Be Completed by 3 Widowed 4 Divorced white Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law/Education Law Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cyrus Wechsler Loretta Bernstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2914 Garfield Street, N.W., Washington, DC 20008 Fredrica Wechsler Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Chesapeake Crematory 1/19/04 5 ☐ Other (Specify) Beltsville, MD 4 | Donation 21 Name and Address of Facility
Simple Tribute Funeral and Cremation Center
10040 Rockville Pike, Rockville, MD 20852 21. Signature Funeral Service Licenses 2 1. Inter the disease, or one lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician end I for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records. P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown \$ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 1 ☐ Yes 2 ☐ No tLl Yas 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury et Work? 27. Mennes of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after daath.

Director: Aft
d in by tha fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) complataly fillad in by 4 - Homicide 24 hours 29a. Certifier Cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai ed manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kin 30. Name and eddress 6121 Montrose Rd Rockville MD

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Regist

			State of Maryland / De State of Maryland / De State Amend Item 26 per Verb., G827, 01/21/046	partment of Health and M ertificate of Death	ental Hygie	ne No. 2004	01298
	Physici		1. Decedent's Name (First, Middle, Last) Rosemary F. Weyback		Date of Death	Day004 Year	3. Time of Death 12:15 Am
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 709 Maiden Choice Ln. Apt. 8T05	4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	2
	Funeral Director		5. Social Security Number 6. Sex $1 \square$ M $2 \square$ F 7. Age (In yrs. last birthd $077-14-4997$ Usual Residence of Decedent	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 19,		ace (State or Foreign try) York
	Marylend a-f ehow	tor	10a. State Maryland Baltimore 10b. County Catons	Location Ville		10	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23s or 28 let be not	al Director	10e. Street and Number 709 Maiden Choice Ln. Apt. 8T05	10f. Zip Code 21228		Citizen of What Count J. S. A.	ry?
336	s within 72 hours after death with the Marylend Jene. Ir than "natural", or iteme 23a or 28e-f ehow Ithe Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2♥ No Specify: 1 ☐ Yes 2♥ No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whit	etc.
21215-0036	within ane. Ihan "	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working. B. DO NOT use retired) Istant manager	ng	Sanking	ustry
Maryland 2	s 1 and 2 should be filed to the filed and Mental Hygie liem 27 ie marked other to other traumatic event,	To Be Co	17. Father's Name (First, Middle, Last) Frederick Fredericks		(First, Middle, Maid Stirratt	den Sumame)	
	1 and 2 sho Health and I em 27 ie ma		The second secon	ailing Address <i>(Street and Number or Rur</i> a 102 Columbine St. (<i>l Route Number, Ci</i> Great Fall	_	^{Code)} 2066
Baltimore,	permit. Pages 1 a Department of Hea Important: if Item eny injury or othe		Cemetery,	sposition (Name of crematory or other place) 01-13 Washington Memorial	5-03	Location - City or Tov Paramus, Ne	
Bait	permit. Departr Import eny inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ambrose Funeral Hom 1328 Sulphur Spring	Rd. Arh	outus, MD.	21227
68760,	Physician /Medical Examiner upon policies and private upon policies and private interpretation of the private interpretation o	dical Examiner	23d. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Curebrovatulu.	v disc	246	Approximate Interval Between Onset and Death
P.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Medic		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	a cause of death?
al Records,	The ate h	Completed	thrombophlebith legs	beli, delprinous	24a. Was an autopsy performed 1 Yes 2	? prior to com death?	sy findings available pletion of cause of
of Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2/2 No Hospital: 1 Inpatient 2 ER/Outpa			6 ☐Other (Specify)	
Division o	Hospitel by Attending Ph 14 hours after death. Funeref Director; After th tely filled in by the funeral	Certification:	27. Manner of Death 1 A Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury At home, farm,	y Work? M 1 Yes 2 No		and Number or Rural	Route Number,
څ	pitel or some after present pire	I Certi	4 ☐ Homicide building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place, a	City or Town, St		ted.
	the the	Medical					
)			1 Hours III	0000004		(10 po	
	2)		29b. Signature and title description and manner stated. 29b. Signature and title description who completed cause of death (Item 23a) (Type 2 and 2 and manner stated). 30. Name and address of person who completed cause of death (Item 23a) (Type 2 and	Chanie land, C.	atoun	relle, MA	2/228
	Sta Registr	te ar	JAN 2 1 2004 32. Registrar's Signature	de			

			1 - For State Registrar	State of Maryla	•	nent of Health cate of Deat			giene Neg. No. 2	004	01300
	Dhusiai	2.0	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	th Day	Year A	3. Time of Death
	Physici /Medio		Wayne	Thom		Waters		BNUBRY	16 2	2004	511 PM
1	Examin	er	4a. Facility Name (If not institution, give			City, Town, or Location	on of Death	>	4c. County	of Death	
			5. Social Security Number 6. S	, - ,	MORE Inst birthday) If	120001	der 24 Hrs.	8. Date of Birth	2	0 Pirtholog	ce (State or Foreign
	Funeral Director			2 F 50	Yrs. Mc	nths Days Hour		(Month, Day 08 24	(, Year)	Country M)
			Usual Residence of Decedent	50				O			
	yland		10a. State 10b. County	10c. C	ity, Town or Location	n				10d	. Inside City Limits
	e Mar	cto	MD NA	Ba	ltimore						¹XXes 2□No
	or 28	Oire	10e. Street and Number		1	of. Zip Code			10g. Citizen of \	What Country	1?
	death with the Maryland me 23s or 28s-f show I must be notified at	ra l	4401 Liberty He			212				5.A.	
	item item	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was	Decedent of Hispanic , specify Cuban, Mexi	Origin? (Sp ican, Puerto	ecify Yes or No- Rican, etc.)	14. Hac	e - American ck, White, etc	
36	I' or	by F	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2550 If Yes, Give Year or Dates:	10	es XXNo Spec	eify:		Specify	Blac	ck
21215-0036	72 hours after natural', or ite dical Examina	ted	15. Decedent's Ed		16a. Decedent's	Usual Occupation			16b. Kind of B		
215	within 7, ene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	of work done during m OT use retired)	nost of work	ang			
7	d wit	Го	12th grade	na	Plum						mbing Co
pu	be filed ntal Hygid of other avent, iii	Be (17. Father's Name (First, Middle, Last,					e (First, Middle,		16)	
<u>ya</u>	should Ind Men	မ	Wardell Water					Camero			
Maryland	2 sh end te m		19a. Informant's Name/Relationship (dress (Street and Nur					
	1 and Health Ism 27 other tr		Vellette Waters 20a. Method of Disposition	3-Wife		olumbus I	The same of the sa	Balt Date	20c. Location -		21215
סר	Peges nent of h int: If Ite		Murial 2 ☐ Cremation 3 ☐	JHemovai irom State	Place of Disposition cometery, cremator		1				
Baltimore,	nit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heath end Mental Hygiene. ortant: if Item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic avent, the Madical Examination and be notified at a.		* 4 □ Donation 5 □ Other (Specifical Service Licer)			rial Par. me and Address of Fa		21/04	Randa.	LIsto	wn, Md
Ba	permit. Pege Department Important: If any injury or once.		20. W/		Mar	ch F/H W	est	n 1!			
	8		23a. Part1. Enter the disease, or com	plications that caused the dea		O Wabash mode of dying, such				A	pproximate
A.	Dhysisian	i	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	CONTIC	CO CON LAY	20 1	DTFDU	DICE		iterval Between Inset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		CORONAR	10	NEXI	11067		
	Examiner			h							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	querice st):						
	nd nd transi	Examiner	that initiated events	c							
90,	e exe		resulting in death) Last	Due to (or as a conse	quence of);						
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical		d							
9	eath certific attending pl for use as f	/Me	IF FEMALE:	23c. If yes, outcome of pregi	32004						
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fe	al death 3 Ecto	pic pregnancy er (specify)				te of delivery nth Da	ay Year
P.0.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	3000	er (specify)					
			Part II. Other significant conditions of	contributing to death but not re	sulting in the under	ying cause given in Pa	art I.	23e. Did to	bacco use cont	ribute to the	cause of death?
Division of Vital Records,	law requires as been sign 2 should be	d by	HIV					1 🗆 Y	es 2 🗆 No	3 Probab	ly 4 dunknown
00	w requir been si should	lete	/					24a. Was a	ın 24b. \	Were autopsy	findings available
Re	o _ c @	Completed						autop: perfor	med?	prior to comp death?	letion of cause of
ta	ilcian: Th certificate rector, pag	a	25. Was case referred to medical			26. Pl	ace of Deat	1 ☐ Yes h (Check only or		I□Yes 2f	□No
>	Physician: this certificant	0 8	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3	Othor		me 5 Resid		er (Specify)	
0 (ding Phys I. Atter this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe h			
ioi	Attending r death.	atlo	2 Accident investigation	n	N		□No				
Ν	l or Attano after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			actory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural R	loute Number,
۵	spitel cours at nerel D										
_	左4 L 0	edical	(Check only 2 Medical Expr	nysician: To the best of my kr miner: On the basis of examin	nowledge, death occurrence and/or investigation and/or investigation	urred at the time, date pation, in my opinion, o	and place, death occur	and due to the c red at the time, d	ause(s) and ma late and place, a	inner as state and due to th	ed. e cause(s)
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License numbe	er		9d. Date signed	d (Month Da	v Year)
	with To 1	-	b. Signature and title of pertinel	110		10.	1-61		_		5 2004
7	0		30 Name and address	appropriate and a state of the state of	om (2a) (Time Dill	2003	1706		JANUSI	U 16	3 200 7
4	4		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type, Print	1405 P. +	91				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr s Sigr		1	- 1				
	Registi		JAN 2	1 2004 > Miner	w St A	328466					

			1 - For State Registrar	State of Maryla		ment of He icate of D	alth and N		ne 2001	01201
			1. Decedent's Name (First, Middle, Las	st)		icate of D	Catr	Reg.	NOS UUN	3. Time of Death
	Physici		ROS-0	3 (1)hpe	ler				Day Year	0:10 AM
	/Medic Examin		4a. Facility Name (If not institution, give		-	c. City, Town, or Lo	ocation of Death	Junuary	4c. County of Dea	th
		ler	Sinni Hox	nital of Bo	Dimno	Contin	MORP P	itu		
	Funeral		5. Social Security Number 6. S				If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Bi	thplace (State or Foreign
	Director		212.60.5319 1	OM 2017	53 Yrs. M	onths Days	Hours Min.	(Month, Day, Ye	50	mD D
	pg		Usual Residence of Decedent							
	the Marylar 28a-f show	_	10a. State 10b. County	10c. C	ity, Town or Locati	on				10d. Inside City Limits
	Ba-f s	50	1111)	10	ACtim	ore				1 ☐ Yes 2 ☐ No
	or 28	E C	10e. Street and Number	. 0	1	Of, Zip Code		10g.	Citizen of What C	ountry?
	death with the Maryland ms 23a or 28a-f show ringst be rediffed at	ïa.	33/3 Croya			2190	7		USA	
	ter dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am- Black, Whi	
38	rs aft	by F	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates;	10	Yes 200 No	Specify:		Specify:	linet
200	72 hours "natural", alical Exa	ed	15. Decedent's Ed		16a Decedent	's Usual Occupation	on	16h	Kind of Business	Industry.
25	in 72 n ne	Completed	(Specify only highest gra	de completed)	(Give kind	of work done dur. NOT use retired)	ring most of work	ing	Traile of Desiriess	/industry
7212	with jene.	E	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	000	rator	-	Ω	Horo (moany
35	illec I Hyg othe	Bec	17. Father's Name (First, Middle, Last)				8. Mother's Name	e (First, Middle, Maid	en Sumame)	7
an C	should be filed within and Mental Hygiene. marked other than matic event, ILE M.	ToB	Hauwood CIA	Lat			anie	M	3 (clan.	7
9Se (λ Marylano	nit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla ariment of Health and Mental Hygiene. ortant: If tiem 27 is marked other than "natural", or flems 23a or 28a-f shor Injury or other traumatic event, the Medical Exercit et insist be refitted at a	-	19a. Inf ant's Name/Relationship (7	ype, Print) /	19b. Mailing A	ddress (Street and	d Number or Run	al Route Number, Cit	y or Town, State,	Zip Code)
_	1 and 2 a Health ar Iom 27 is		Royald S. Wheel	ler Hushand	33/3	Condon	Rd P	Altomore	mn 2	1707
or ē	es 1 and of Health fitem 27 rother tr		20a. Method of Disposition	20b.	Place of Dispositio	n (Name of	The second second		Location - City or	
\mathcal{K} Baltimore,	permit. Pages Department of Important: If i any Injury or once.		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		M	rial Acri	1-24	1.04 RG	1/1/10/10	01/3
Ħ	mit. I partm portar Inju		21. Signature of Funeral Service Licen			me and Address	of Facility \Qu	19h. C. Green	e Forest	Services
ä	Depa Impo any Ir		Naugh ()	hoono	82:	28 / hor	to Pd F	andalls tre	n, mo 21	133
			23a. Part1. Enter the disease, or comp	dications that caused the dea	th. Do not enter th	e mode of dying,	such as cardiac	or respiratory arrest,	1,119000	Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final	A C C C C C	1001	action 1	Oicene	1:		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. ASCEALA Due to (or as a conse	dience di	Oltic 1	11726C	Fron		15days_
1	Examiner				43311333					
M		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a nonse	quarios of):					
U	ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	ite be executed iysician and ne burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
094	ate be ex nysician he burial	icai		d						
ŏ	death certifica attending ph for use as t	Physician/Med	230. was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		opic pregnancy			23d. Date of de	ivery
<u>.</u>	he deat	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of		ner (specify)			Month	Day Year
Ö.	that the de ed by the detached	Å.	9 🗆 Unknown	9□ OUKUOWII	·					
Division of Vital Records, P.O. Box 66	s Go	by	Part II. Other significant conditions co		/		in Part I.	23e. Did tobacc	use contribute to	the cause of death?
Ď	w require been si should t	be	multiple 1	prain infl	uctions			1 🗆 Yes	2 (110 3 □ Pr	obably 4 ∐Unknown
ပ္စ	aw re as be 2 sh	Completed by	Renal Kailes	70				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
æ	The I	E						performed?	death?	_
ital	ician: The lav certificate has rector, page 2	Bec	25. Was case referred to medical	a		26	6. Place of Death	(Check only one)	.0 12100	2010
>	ding Physician: The Ingress The After this certificate had funeral director, page	ToE	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:	4 Nursing Ho	me 5 Residence	6 □Other (Spe	cify)
0	ding Pt		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how in	jury occurred	
<u>.</u>	ttendir death. ctor: Af y the fu	atic	2 ☐ Accident investigation				s 2□No			
	or Atterdenterde Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, street,	factory, office		28f. Location (Street City or Town, Sta	and Number or Ru	ral Route Number,
۵	rs after rs after ral Dire	Cer		1						
	dospi t hou uner: uner	cai	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exam	ysician: To the best of my kn liner: On the basis of examin	owledge, death occ	curred at the time,	date and place,	and due to the cause	(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	One;	and manner stated.						
	To To Corr	2	29b. Signature and title of certifier	/	111	29c. License ni			ate signed (Monti	
			Toe	querra p	1.1)	D0024	726	Jan	Vary - 19	7-2004
	5		30. Name and a dress of person who	mpleted cause of death (Ite	m 23a) (Type, Print)		Jan e Baltim		21215
100			Alesanary Seq	veira 2401	Wist Be	lyeder é	A Yenuc	2 baltim	oce.mai	yland
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	2.00 Cold				-

			. For	State of Maryland				Mental Hyg	iene _	001	01000
			1 - State RegistrapAMFND ITEM #1 F	ER PHY G827 1/23	104 Fie	rtificate of l	Death		eg. No.	UUU	01302
	Physicia	an	Decedent's Name (First, Middle, Last,	Content of the conten				2. Date of Dea Month	th Day	Yeer	3. Time of Death
	/Medic	al		H. WILLIAMS, J1	r	4b. City, Town, or	-S	Jan	15 40 CO	unty of Deeth	0238 AM
	Examin	er	4a. Facility Name (If not institution, give The Johns Hopk)		(-) 11.	LOYE (itu	40.00	umy or Deeur	
F	uneral		5. Social Security Number 6. Sec	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	9. Birthp	place (State or Foreign
	irector		218-46-5530	JM 2□F 53	Yrs.	Months Days	riodis iviii	Aug. 16	1950	Mar	yland
and	M. T		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation				1	Od. Inside City Limits
Maryl	finds	tor	Maryland NA	Ва	altimo	re					1 XYes 2 ☐ No
th the	123a or 28a-f show well be notified at	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cour	ntry?
ath wi	23a	rai	814 Collington			21205				U.S.A.	
er de	itams ner m	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- into Rican, etc.)		Race - Americ Black, White,	
-0036 hours after death with the Maryland	atural', or itams cal Exeminer m	þ	3 Widowed 4 Divorced	ty⊟Yes 2 ⊟No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spi	ecity: Blac	ck
	lical i	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupa	ation during most of w	orking	16b. Kind	of Business/Inc	dustry
- 2121 ; within 72 ene.	P. W.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			_	
d 2 filed v	ther t		17. Father's Name (First, Middle, Last)	3	Prob	ation Off		ame (First, Middle,			ction Dept.
id be	D &	To Be	Charles		Willi	ams	Emma			Will:	iams
Maryland d 2 should be file th and Mental Hy	itsm 27 is marke other traumatic	-	19a. Informant's Name/Relationship (T)		1	ng Address (Street			-		
	n 27 l er tra		Danielle William								
attimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other plac	Jai	nuary	20c. Locati	ion - City or To	wn, State
t. Pag	important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	100)		Crematory 2. Name and Addres		1.2004	Balti	more, N	Maryland
Ba Permi	any i		21. Signature of Funeral Service Licens	Charache		W. Dabro	wski-Cho	ojnacki F	unera	1 Homes	P.A.
660	100		23a. Part1. Enter the disease, or comp shock, in heart failure. List only o	ications that caused the death	h. Do not en	1005 Dund ter the mode of dyin	alk Ave	ac or respiratory arr	re, M. est,	aryland	Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	Gast mine.	-1	(Alo	0				Onset and Death
/M	ledical		resulting in death)	Due to (or as a consequ	Maria de la companya della companya	COLE					augs
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pe	ısit	nine	cause. Enter Underlying Cause (Disease or injury	Dus to (or as a consequ	uence of).						V
эхөсп	sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
760, te be executed	ysicial ne buri	cail		d							
rtifica			IF FEMALE:						F		
. Box 68 death certifica	attending pr for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	Ideath 3[⊒Ectopic pregnancy	,		23d.	Date of delive Month	ery Day Year
	led by the atter	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5t	Other (specify)					
Records, P.O The law requires that the	igned by be deta	by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	he cause of death?
Records,	(A) (E)							1 🗆 Y	es 2 🗆 N	lo 3 ☐ Prob	pably 4 Unknown
PCO aw re	S CI	Completed						24a. Was a	in 2	4b. Were auto	psy findings available mpletion of cause of
<u>۾</u> ۽	pag	Com						perfor		death?	2 7 No
of Vita Physician:	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 3 DOA Oth		eath (Check only or			-
Phys	this aldii	. To	1 XYes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatie	50 501	4 La 140.0119	Home 5 Reside			v)
Division of Vital or Attending Physician: 1	r: After e funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
VIS	Director: in by the	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, st	reet, factory, office		28f. Location (S. City or Town	treet and N n, State)	umber or Rura	al Route Number,
la la la la la la la la la la la la la l	ral Di							ļ			
Hospita 24 hours	Funeral itely filled	edicai		sician: To the best of my kno iner: On the basis of examina and manner stated.							
To the Hospital or	To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	and many stated.		29c. Licens	e number	2	9d. Date si	igned (Month,	Day, Year)
Γ,	0		1/0/	1		1000	05433	36	Jan	15 2	2004
\			30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type	. Print)	- 10		. 1 .		d 21287
_	\		Michael Stephe 31. Date filed (Month, Day, Year)	32. Registra's Signa	60	0 N. U	Dolte	St Da	Limo	re, m	9 5158J
	Sta		IAN 2	1 2004	S B	(Care	F				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Month Vear . 00 P.N GNOMPA JAN WILSon 2004 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner BAIto. HEIGHTS AVE LiBerTY N.H. 4017 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)
WASA. D. C. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Funeral Days Yrs. 579-40-3611 Usuel Residence of Decedent Director JUN 01 1932 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mentel Hygiene. Important: If Item 27 ie marked other than "natural", or itema 23a or 28a-f ahow any Injury or other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 11 Yes 2□No MD Director BAITIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4017 LIBERT 21207 HEIGHTS AVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BIACK 2 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNK UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. COMM. ON Aging -MS. Lucas 1100 CATHEDRAL St. BAlto. MD. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BAITO. CARMEL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Michael Ziglier Fun Sic, P.A.
P.O. Box 67338 BAHO, MD. 21215 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or o mp rations that caused the death. Do not enter the mode of dying, such as cardiac or residratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner lure The lew requires that the death certificate be executed attending physicien and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, thero Due to (or as a consequence of): certificate has been signed by the signector, pege 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 4⊈ Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 X No 1 Tes 1 ☐ Yes 2 No il or Attending Physician: 1 after deeth. | Director: After this certifica Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a 29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tmatun M Macen MD 503 January 18 2004 7 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Baltimore. MD alait 501 MAEEM 31. Date filed (Month, Day, Year) JAN 2 1 2004 32. Registrer's Signature, Registrar

DHMH 16 Rev 6/95

ORIGINAL

1			1 - For State Registrar	S	tate of N	Marylan	•	artment of			-	giene Reg. No.	2004	01306
			1. Decedent's Name (First, Middle	Last)							2. Date of Dea	ath Day	V	3. Time of Death
	Physici /Medio		David Alan Ze	iders	3						January		Year 3, 2004	2:06 P M
	Examin		4a. Facility Name (If not institution,			er)		4b. City, Town	, or Location	of Death		4c.	County of Dea	th
			4507 Norrisvill	e Ro	ad				Hall				Harfor	
	Funeral		5. Social Security Number	6. Sex	2□ F		last birthday)	If Under 1 Yea Months Day		Min.	8. Date of Birt (Month, Da June 9	th y, Year)	9. Bir	thplace (State or Foreign ountry) 1Sylvania
	Director		205-56-2654	1 90 141	201	39	Yrs.				June 9	,196	4 Penr	nsylvania
	and *		Usual Residence of Decedent 10a. State 10b, County			10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	f ehc	ō	PA Lancas	ter				С	olumbi	.a				1 ☐ Yes 2 🛂 No
	28a	Director	10e. Street and Number					10f. Zip Code)			10g. Citi	zen of What Co	ountry?
	3a or	Ö	160 Stonehouse	Lan	_				17512	2		U	.S.A.	
	death	Funeral	11. Marital Status		Was Decede	nt Ever in U	.S. 13.	Was Decedent o	f Hispanic Or	rigin? (Sp	ecify Yes or No	-	14. Race - Ame	
9	or ite	Ē	1 ☐ Never Married 2 ☐ Marri	be	Armed Force			ir Yes, speciny Ci 1 □ Yes 2 ☑ N			Hican, etc.)		Black, Whit	te, etc.
93	72 hours after death with the Maryland natural', or itema 23a or 28a-f ehow Jisal Examiner rount be mutified at	d b	3 ☐ Widowed 4 ♣ Divorced		If Yes, Give Year or Date	s:		10 163 20014	o Specify.	•			Specify: wl	nite
5	72 h 'natu	Completed by	15, Decedent (Specify only highes				(Give	dent's Usual Occ kind of work dor	e during mos	st of work	ring	16b. Ki	nd of Business	/Industry
21	within ene. then	du	Elementary/Secondary (0-12)		College (1-4d	or 5+)		DO NOT use reti	red)			_	onstru	ation
2	e filed within It Hygiene. other than		12 17. Father's Name (First, Middle, I	acti				Laborer	18 Moth	ar's Nam	e (First, Middle,			SCION
anc	Mental Parked of arked of atic even	Be	17. Father's Name (First, Micore, I		hard L	701	lore				O'Tool		Surname	
Ž	2 should be and Mental ie marked eumatic ev	ဥ	19a. Informant's Name/Relationsh			. 201		ng Address (Stre					r Town State	Zin Code)
<u>≅</u>	d 2 s lth an 27 ie 1 trau		Richard L.Zeider		-		401	North 5t	h Stre	eet 1	Newport,	Per	nsylva	nia 17074
e,	ges 1 and 2 should be filed within 72 hours after death with the Marylan 1 of Health and Mental Hygiene. If Item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumatic event, the Madical Examinational be natified at		20a. Method of Disposition				Place of Dispo	sition (Name of matory or other p	(aca)		Date	20c. Lo	cation - City or	Town, State
9	Pages nent of int: if its iry or o	1	1 Burial 2 □ Cremation 1 Donation 5 □ Other (St		oval from Sta	10	-	Cemetery	· .	1/17/	2004 N	lewpo	rt, Per	nnsylvania
Baltimore, Maryland 21215-0036	그 된 환경	1 8	21. Signiture of Funeral Service I					-		ity M i 1	 lar=Dir	ne 1	Funera	1 Home, Inc.
ä	Department Department		Julia	M	OSKA		6	415 Rola	ir Rd	R ⊃ 1	ltimore.	Mar	yland	21206
			23a. Pert1 Enter the disease, or short, or heart failure. List	complicat	ions that caus	sed the deat	h. Do not ent	er the mode of d	ying, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition		M	etin	4 1	winds	Law					Onset and Death
	/Medical		resulting in death)	€ a	Due to (or	as a consec	uence of):	7 4,00						
- 3	Examiner		Sequentiafly list conditions,	b										
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to [or	as a cons	uence of:							l l
	and and I-tran	хап	that initiated events resulting in death) Last	с.	Due to for	as a conseq	neuce ot).							
8760,	be executed sician and burial-transit	alE												
687	ate hy	edical		d										
×	eath certific attending pi	/Me	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, outcor								23d. Date of de	livery
Вох	death atter	ciar	in the past 12 months?		1 ☐ Live birth			Ectopic pregnar Other (specify)	ncy				Month	Day Year
o.	at the de by the a	Physician/M	9 Unknown		9□ Unknowr	1								
٦,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	ns contrib	outing to deat	n but not res	ulting in the u	nderlying cause	given in Part	1.	23e. Did to	obacco u	se contribute to	the cause of death?
Vital Records,	w require been sig should b	leted t									101	/es 2[□No 3□Pi	obably 4 Unknown
000	aw re as ber 2 sho	piet									24a. Was			utopsy findings available
Ä	0 - 2	ompi									perfo	rmed?	death?	completion of cause of
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Plac	e of Deat	h (Check only o		-	
of V	S S	70	1 X Yes 2 □ No	Hos	1 L Inpa		ER/Outpatier	IL 3 DOA		ursing Ho	ome 5 🗆 Resid	dence 6	Sther (Spe	city) at scene
	fing Ph). After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending		28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	l W			28d. Describe h	now injur	y occurred	us land .
sio	at :: e	cati	2 Color investig 3 Suicide 6 Could n	ot be		3 lox	ok.		□Yes 20	No	J. J	60	hule	raccident
Division	or Attand after death Director: d in by the f	Certification:	4 Homicide determi	ned	28e. Place of building,	Injury - At h etc. (Special	ome, farm, str	reet, factory, offic	:8		28f. Location (S City or Tox			Vores vill
	ortal ors a oral C		00- 0-49 10 0-44	- Dt1-1			west	7			-	that	Hill, 1	rongland
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 Certifyin (Check only 2 Medicel I	y rnysici Examiner	an: To the be : On the basis and manner	s of examina	wiedge, deat ition and/or in	h occurre at the vestigation, in my	ume, date ai y opinion, dea	nd place, ath occur	and due to the or red at the time, or	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier		and manner	stated.			nse number				e signed (Mont	
	₩ 3 F 8		1/1	11	1	/	0		O.C.	M.E.			ary 14,	
	0		30. Name and address of person	who comm	feted cause	of death (Iter	n 23a) (Type	Print)			1			
	\		THEUDOA		. 6	(1101		l11 Penn	Stree	et. F	altimor	e. M	arvland	3 21201
	Sta	ite	31. Date filed (Month, Day, Year)		32. Beg i	strar's Signa		C.N.		_, _				
	Registr	ar	JAN 2 I	. 2004	A. S.	EMON .	AS AA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1-12-04 For sheed #1.Per Phys. State of Maryland / Department of Health and Mental Hygiene 1-8-04 Registrashmend#'s 28b.& c.Per MED PGC cr Certificate of Death Reg. No. Leslie Telli Achuo 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MATHOI 40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beltinore Shock Trauma Center RAdams Conley If Under 1 Year | If Under 24 Hrs. 5 Social Security Number . Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F June 8, 1979 Director 432-95-3494 24 Cameroon, W.A. Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1∏Yes 2☐No Director Arlington Va. Arlington 10g Citizen of What Country? 10e. Street and Number 10f. Zin Code or Items 23a 26 S. Old Glebe Road, #105 22204 Cameroon, W.A Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lies any injury or other traumatic event, Iles Medical Examinat ODE. 1 Never Married 2 Married
3 Widowed 4 Divorced ☐Yes 2☐No fYes, GivXX Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. þ Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5yrs Elementary/Secondary (0-12) Student none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Matthias Achuo Lucienne Kamga Che ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 S. Old Glebe Rd. #105, Arlington, Va. 22204 Kristy Greenwalt/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St/ Joseph's Cathedral 1/17/04 Bamenda, Cameroon, W.A. 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Funeral Service Licensee 716 Kennedy St., N.W. Wash. D.C. 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Blunt traumat disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death
4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) be detached Yes 2 No P.O. 9 Unknown 9 Dunknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 Probably 4 Unknown 1 Yes peeu 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner?

1 Pres 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this s after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 8:49 AM 5 ☐ Pending 1 Natural 28t. Location (Street and Number or Rural Route Number, City or Town, State) BUN Hat and MUNAHAT 1 ☐ Yes 2XXNo investigation 2 Ccident 8:49 AM 1 = 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. filled 24 hours 29a. Certifier Medical To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)46147 · Chin no -(

State Registrar

Lin, 31. Date filed (Month, Day, Year) JAN 0 8 2004

William C.C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

1- State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health and Mental Hygiene 2 1 1 State of Maryland / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andr 01306

Market Hilliam	I R
Physician /Medical Examiner	1. Dece
Funeral Director	5. Socia

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "neturet", or Items 23a or 28a-f show any injury or other traumatic event, The Mudical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Registrar				or unicate or	Dealii	Reg	. No.	
cian	Decedent's Name JIMMY	(First, Middle, La BENJA	•	ALVAREZ			2. Date of Death Month January	Day Yea 05, 2004	
lical iner	4a. Fecility Name (/	not institution, giv	re street and number)		4b. City, Town,	or Location of Deetl		4c. County of De	
	12000 B	lock Saw	Mill Court		Wheaton			Montgon	nerv
1	5. Social Security N			e (In yrs. last birthda)	() If Under 1 Year Months Days		8. Date of Birth (Month, Day,		Birthplece (State or Foreign Country)
	N/A		1 📉 2 🗆 F	18 Yrs.	Worters Days	Alouis Will.	Dec. 19,		El Salvador
	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or I	ocation				10d Inside City Limits
-	MD.		Georges	Silver					10d. Inside City Limits 1 X Yes 2 □ No
Director				BIIVEI					
Dir	10e. Street and Nur				10f. Zip Code			g. Citizen of What	
Funeral		ersity B	lvd. East A		20903			El Salvad	
un n	11. Marital Status	-d 00 M	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc.
by F	3 ☐ Widowed	ed 2 Married 4 Divorced	If Yes, Give Year or Dates:	.0	1 X Yes 2□ No	Specify: Sal	lvadoran	Specify:	Hispanic
		15. Decedent's E		16a, Dec	edent's Usual Occup	nation	16	Sb. Kind of Busines	ss/Industry
Completed		ify only highest gr	ade completed)	(Giv	e kind of work done DO NOT use retire	during most of world)	king	20. 14110 01 000110	own rousely
E	Elementary/Seco	ndary (0-12)	College (1-4or 5		orer			Constru	uction
BeC	17. Father's Name)		0101		ne (First, Middle, Ma		
To B	Cirilo A	Alvarez				Ana S	Silvia Cru	ız Avelar	9
	19a. Informant's Na	me/Relationship (Type, Print)				ral Route Number, (City or Town, State	a, Zip Code)
	Ana Sil	ia Cruz	Avelar (Mo	ther) 35	511 13th S	St., N.W.	#4 Wash:	ington, I	DC 20010
	20a. Method of Disp	osition		20b. Place of Disp	position (Name of ematory or other pla	cal	Date 20	c. Location - City	or Town, State
		☐Cremation 3 ☐ 5 ☐Other (Specia	Removal from State (v)		Cemetery	. 1	18. 2004	La Unic	on, El Salvad
	21. Signature of Fu		• •		22. Name and Addre	4 400 141			
	> Wani	ta C.	Bacon C	1		W	и. н. васс Washingt	on Funera	1 Home, Inc.
	23a. Part1. Enter th	e disease, or com	plications that caused	the death. Do not er					Approximate
	shock, or hea Immediate Cause (ttailure. List only	one cause on each lin	10.					Interval Between Onset and Death
	disease or conditio resulting in death)		a gunsh	of wou	nd ot	abdom	en		
		- 1	Jue to (or as	a consequence of):					
50	Sequentially list con	ditions,	b. Due to for as:	a consequence of.					
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an/Medicai	IF FEMALE: 23b. Was decedent	araanan!	23c. If yes, outcome	of pregnancy				23d. Date of d	folivery
	in the past 12	months?	1□Live birth 4□Pregnant at	2 Fetal death 3 time of death 5	□Ectopic pregnancy □ Other (specify) _	у		Month Month	Day Year
ıysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	INO	9□ Unknown						
Completed by Physici	Part II. Other signif	cent conditions	contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
q p							1 🗆 Yes	2 No 3 🗆	Probably 4 []Unknown
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μ							autopsy performe	prior to	autopsy findings available o comptetion of cause of ?
ပ္ပ	25 111						1X Yes 2	No 10 Ye	es 2□ No
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- To	1 Yes 2 ☐ 27. Manner of Death		1 L Inpatie		of 28c Inur	4 Nursing H	ome 5 Residence	to 6 Other (Sp	pecify) (scene)
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ica	2 Accident 3 Suicide	6 ☐ Could not b		iry - At home, farm, s	7	163 2 2 100	286 Location (Stm	yeard Mumber of	Cored Courts Number
ertif	4 Homicide	determined	building, etc	(Specify)	1	-	281. Location (Sire	States LOC	Rural Route Number
Ö	29a. Certifier	1□ Cartifuing Ph	COC.	In to	-	07	Wheek	00 1	10
Medical Certification:		2 Medical Exar	nysician: To the best on niner: On the basis of and manner sta	examination and/or is	nvestigation, in my o	ppinion, death occur	red at the time, date	se(s) and manner a and place, and do	as stated. ue to the cause(s)
Me	29b. Signature and	title of certifier	and mailings Std		29c. Licens	e number	29d	. Date signed (Mor	nth. Day. Year)
	P		- PO	01	0.C.			nuary 6,	
	30. Name and addre	ess of person who	completed cause of de	eath (Item 23a) (Type	, Print) 111 P	onn Ct	+ Dal+4	omo 24-	21201
	MATRI		ONICA- PO	MAK W) III b	enn Stree	et, Baltim	ore, Mar	yland 21201
ate rar	31. Date filed Want	0 9 2004	32. Registra	r's Signature	K.,				
2001			1-000	- Marie					

Registrar

			1 - For State Registrar		artment of Health and rtificate of Death	Mental Hygier	_ ZUUG
3000	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last) CHRISTINE MARIE ANA Aa. Facility Name (If not institution, give street and	ASTASI-HAMMOND	4b. City, Town, or Location of Deat	January 3	Day Year 3. Time of Death 11:06A M
	Funeral Director	ier	Greater Laurel Regions 5. Social Security Number 216.82.0415 6. Sex	1 Hospital 7. Age (In yrs. last birthday)	Laure 1 If Under 1 Year If Under 24 Hrs Months Days Hours Min.	- 8. Date of Birth	Prince George s 9. Birthplace (State or Foreign Country)
s, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28s-f show other traumatic event, ILM Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George 10e. Street and Number 8919 57th Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Joseph Anastasi 19a. Informant's Name/Relationship (Type, Print) Helen E. Anastasi/Moth	accedent Ever in U.S. Forces? s 2 1 No Gree r Dates: 16a. Dece (Give life. ACCOU	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry .ndows Replacement an Sumame) vor Town, State, Zip Code) , Maryland 20740		
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify) Entom 21. Signature of Funeral Service Licensee	bment Fort Lin	matory or other place) Mausoleum 101/0 coln Cemetery Mansand Address of Facility ORT LINCOLN FUNER.	7/2004 Bre	Location · City or Town, State entwood, Maryland rood, Maryland 20722
/60,	death certificate be executed Barbarding physician and cortice as the burial-transit dorting as the principle.	Ical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause United by that initiated events C.	at caused the death. Do not enthe each line. 2 umonia to (or as a consequence of): 3 Syndrome to (or as a consequence of): 5 (or as a consequence of):	er the mode of dying, such as cardiad	c or respiratory arrest,	Approximate Interval Between Onset and Death
O. Box 68		Physician/Med	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Hecords, P.	requires that been signed should be de	Completed by Ph	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	1 ☐ Yes	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of
or vital	Attending Physicien: The law r death. ector: After this certificate has l by the funeral director, page 2 s	To Be	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	S Inpatient 2 ☐ ER/Outpatien e of Injury onth, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 Nursing H	performed? 1 Yes 2 No No No No No No No No No No No No No	1 Yes 2 No 6 Other (Specify)
DIVISION	Hospital or 4 hours afte Funeral Dir ely filled in	edical Certification:	29a. Certifier (Check only) 29 Medical Examiner: On the	basis of examination and/or inv	eet, factory, office coccurred at the time, date and place restigation, in my opinion, death occu	City or Town, Sta	c) and manner as stated
	To the Hos within 24 h	Med	29b. Signature and title of padifier 30. Name and address of person who completed ca	McD.	29c. License number D-54853	29d. D	ate signed (Month, Day, Year) uary 3, 2004
	Sta Registr	te ar	Danny Lee, M.D., 8317 31. Date filed (Month, Day, Year) JAN 0 6 2004	Cherry Lane, I		20707	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year AMBERMANJR 16=15P M JAMES THOMAS IAN 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DE MEMORIAL HAJRG HARFORD HOSPITAL GLACE ERHALFOND 6. Sex 120 M 2□ F If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 217 - 58 - 867 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Haure de Grace Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at Maryland berdeen 1 ☐ Yes 2 No Directo Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces 2 1 | Yes 2 2 No 00 000 21001 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 No ۵ lf Yes, Give/ Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 1F-employed 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any jury or other traumatic avent 2008. Be 18. Mether's Name (First, Middle, Maiden Surname) Thomas James Amberman Nel MOFFI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen Amberman Sr-Father Stepney 1100 Morth 29 MPC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * Air Memorial Goodbuc 2004 Be • 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Kame and Address of Eacility Funeral Home, PA Parke herdeen 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALUTE CORONARY ALTERY /Medical Due to (or as a consequence of): Examiner ASLUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

this certificate has been signed at director, page 2 should be del Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Certification:

ERMA

AMES

1 Yes 2 No

1 ☐ Yes 2 MNo

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 TYes 2 TNo 21 Accident

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

man M.D.

021809

MONOWIL

29c. License number

29d. Date signed (Month, Day, Year) JAW 5, 2004

MD 21093

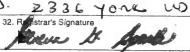
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9-5. PRASHUM.D. 2336 YONG

State Registrar

Medicai

31. Date filed (Month, Day, Year) JAN 2 1 2004



		Plea	ise Type or	Prir	nt in I	Black Ind	delible	e Ink.	Ensu	ire A	II Copies	Are L	.egible.
	1_ For State		State of	of Ma	arylar	nd / Depa	rtmer	t of H	lealth a	and M	fental Hy	giene	2001
	Registrar					Cei	tificat	e of i	Death			Reg. No.	11000
	Decedent's Name	•									2. Date of De Month	Day	2000
	Ezekiel 4e. Fecility Name (/		Ayotunde n, give street and nu	ımber)			4b. City,	Town, or	Location -	of Deeth	Decrio	-	County of Dea
	Doctor'	s Hosp	ital				Lan	ham				Pr	ince G
	5. Social Security N	lumber	6. Sex			last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th Vesci	9. Bir
	577-78-2	266	1 ☑ M 2 □ F	-	57	Yrs.	MOTHERS	Days	riours	(VIII).	8. Date of Bir (Month, Da 6 12	194	46 Ni
	Usual Residence of	Decedent											
	10a. State	10b. County	,		10c. C	ity, Town or Lo	cation						
	MD	Princ	e George'	s	G	reenbel	t						
2	10e. Street and Nur	mber					10f. Zip	Code				10g. Citize	en of What C

of Health and Mental Hygiene 2004 01309

1. Decedent's Nar Ezekiel												
		de, Last) Avotunde						2. Date of Dea Month	Day	200	34	3. Time of Death 2:25A
		on, give street and nu	ımber)		4b. City, Town,	or Location	of Deeth			County of (Death	
Doctor	's Hosp	oital			Lanham				Pr	ince	Geo	rge's
5. Social Security 577-78-2	Number	6. Sex 1⊠ M 2□ F	7. Age (In yrs. Ia 57	ast birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt Month, Day	h	9.		ace (Stete or Foreig
Usual Residence								0 17	+ /	70 1	TEC	
10a. State	10b. Count	ty	10c. City	, Town or Lo	cation						10	Od. Inside City Limits
MD	Princ	ce George'		eenbel								1∭Yes 2□No
10e. Street and N	umber				10f. Zip Code				10g. Citiz	en of Wha	t Coun	try?
8531 A	Greenbe	elt Rd # 2	02		20770				U.S	.A.		
11. Marital Status 1 Never Mai 3 Widowed		rried Armed F	213 No ive	li li	Was Decedent of f Yes, specify Cut 1 ☐ Yes 2 ☑ No	an, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		4. Race - / Black, \ Specify:	White, 6	
(Spe		ent's Education est grade completed)		(Give	lent's Usual Occu kind of work done DO NOT use retire	during mos	st of worki	ing	16b. Kin	d of Busin	ess/Ind	lustry
Elementary/Sec	ondary (0-12)	College (5+	1-4or 5+)	Specia					Pr	ivate		
17. Father's Name	(First, Middle	i, Last)				18. Moth	er's Name	e (First, Middle,	Maiden S	Sumame)		
Festus	Samuel	Ayotunde				Et	m <u>i</u> lia	ı	0a	ebode	9	
19a. Informant's N Beverly		nship <i>(Type, Print)</i> nde-Wife		19b. Mailin 8531 <i>A</i>	g Address (Stree A Greenbe	and Numb	er or Rura 1. #	202 Gre	r, City or enbe	Town, Sta lt, M	te, <i>Zip</i> lary	^{Code)} 1and 2077
20a. Method of Di 1 ⊈Burial 2 3 4 □Donation	Cremation	3 □Removal from	State Cer	metery, cren	sition (Name of natory or other plattion Cem			Date -2004		ation - City		
21. Signature of F	uneral Service	e Licensee	1		Name and Addr 474 Lanc			B. Jen Landov				
00- 0-44 (F-1-	the disease, o		caused the death	Do not ente	er the mode of dy	ng such as	cardiac c	or respiratory an	rest,			Approximate
Immediate Cause disease or conditi	(Final	st only one cause on	each line.	teuse								Interval Between Onset and Death
snock, or ne Immediate Cause disease or condit resulting in death	(Final ion)	st only one cause on	each line. Lypev (or as a consequently like C		w	, g, 5551 25						Interval Between Onset and Death
Immediate Cause disease or conditi	o (Final ion) onditions, mmediate lertying or injury ts	a. Due to b. Due to c.	oach line. Lypev (or as a conseque	Choles. ence of):	w	, g, gas						Interval Between Onset and Death
snock, or he Immediate Cause disease or conditi resulting in death Sequentially list of any, leading to icause. Enter Und Cause (Disease of that initiated even	onditions, mmediate lertying or injury ts Last	a. Due to b. Due to c. Due to d	(or as a conseque	ence of):	w				23	3d. Date of Month	deliver	Interval Between Onset and Death Veaus
snock, or he Immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Und Cause (Disease ot that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	onditions, immediate lerlying if injury is last	a. Due to b. Due to c. Due to d	(or as a conseque	ence of): ence of): cy death 3 ath 5	Ectopic pregnance (Cther (specify)	y		1		Month e contribut	deliver	Interval Between Onset and Death Years
snock, or he Immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Und Cause (Disease ot that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	onditions, immediate lerlying if injury is last	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 □ Live I 4 □ Pregi	(or as a conseque	ence of): ence of): cy death 3 ath 5	Ectopic pregnance (Cther (specify)	y		1	bacco us	Month e contribut No 3 24b. Were prior death	deliver	Interval Between Onset and Death Onset and Death One of D

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, if a Marical Examinat must be notified at once.

Physiciai /Medica Examine

Funeral Director

Completed by Physician/Medical Examine Medical Certification: To Be

27. Manner of Death

1 ☐ Yes 2 ☑ No

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

29b. Signature and title of certifier

Steven Remsen

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director.

State Registrar

31. Date filed (Month, Day, Year) JAN 0 7 2004

Keuser

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Yeer)

 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D19446 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1-5-2004

575 Main Street # 351 Laurel, Maryland 20707

2 ER/Outpatient 3 □ DOA

28b. Time of Injury

3	Type of Frint in black indelible in	IIK. E	lisule All	Cobles 1	HIE FE	Jible.
	State of Maryland / Department of	of Heal	Ith and Me	ntal Hyd	iene O	201

ΑI)	-	For State Registrar			d / Depa		ealth an		giene 2001	01310
	Physicia /Medic	al	Decedent's Name (First, Middle, La Sophronia Sophronia Fecility Name (If not institution, gin		Virgini m <i>ber)</i>	.a	Aller			Y 6,2004	3. Time of Death 4:45 a M
2	Examin Funeral Director		8045 BRINKLEY ROAL 5. Social Security Number 6. 5.			last birthday) Yrs.	TEMPLE	HILLS		PRINCE GE	many operate Specific all a
	he Maryland 8e-f show ouilied at	ector		George'	i	y, Town or Lo 1ple Hi	.11s			10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes ※※ No
USP	d within 72 hours after death with the Maryland jiene. Than *natural; or Iteme 23s or 28s-f show the Madical Examinat must be notified at	by Funeral Director	10e. Street and Number 3045 Brinkley Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		edent Ever in U prces? 2 12 140 ve	1)748 ispanic Origin n, Mexican, P Specify:	n? (Specify Yes or No Puerto Rican, etc.)	USA	erican Indian,
Maryland 21215-0036	filed within 72 hou Hygiene. other than "natura ent, the Wedical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired 1e Clerk	during most of		Car Dealers	
Maryland	s 1 end 2 should be fil f Health and Mental H item 27 is marked oth other traumatic even	To Be	17. Father's Name (First, Middle, Las Fenton H. Payne 19a. Informant's Name/Relationship Fenton Payne Jr.	Sr . Type, Print)	ner	1		Elza:	Name (First, Middle ida Marie or Rural Route Numb in, Maryla	Burch er. City or Town, State,	Zip Code)
Baltimore, I	t. Page tment o tant: If ijury or		20a. Method of Disposition 1 □ Burial 2 ☑ ⊈remation 3 ☐ 4 □ Donation 5 □ Other (Special Signature of Juneral Service Lice	Removal from	State 20b.	Place of Disponentery, creates Cre	osition (Name of matory or other place ematory	e) 1/	7/04	20c. Location - City or Edgewater	, Maryland
Ra	Depari Depari Impo		23a. Pent / Enter the disease, or conshock, or heart failure. List only	(m)	caused the deat	h. Do not en	er the mode of dyin	g, such as ca	rdiac or respiratory a		Home PA and 20745 Approximate Interval Between Onset and Death
/60,	Physician percented attending physician and physician and physician and for use as the burial-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	(or as a consection as a conse	uanca of):	nc Car	diov	ascular	disease	
O. Box 68	the death certifica y the attending ph ached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	itcome of pregni birth 2 Feta nant at time of colown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
Hecords, P.	The law requires that the death the has been signed by the atter bage 2 should be detached for u		Part II. Other significant conditions	contributing to d	leath but not res	sulting in the u	nderlying cause give	en in Part I.	10		robably 4 Unknown
Vital Rec		Be Completed	25. Was case referred to medical examiner?							psy prior to death? 2 No 150 Yes	utopsy findings available completion of cause of s 2 No
Division of V	ding Phys n. After this funeral di	Certification: To	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	f 28c. Injun Work M 1 []	4 🗀 INUISI	4	how injury occurred	7 12 1702 1112
ā	Hospitel or Attence Lours after death Funeral Director: etely filled in by the	Medicai Certif	4 Homicide determined 29a. Certifier (Check only 2 Medicel Exe	hysician: To the	ling, etc. (Speci e best of my kno pasis of examina	by) owledge, deat			City or To	Street and Number or R wn. State) cause(s) and manner a date and place, and du	s stated.
	To the Hos within 24 h To the Fun completely	Meo	29b. Signature and title of certific	15	Poli	2e	29c. License OCME			29d. Date signed (Mon	
2	Sta Registr		30. Name and address of person who are filed (Month, Day, Year) JAN 0 7 2004	SONIC 32.1	se of death (Itel	111 ature	Penn Stre	et, Ba	ltimore, M	Maryland 21	201
				1	- ,-	7					

DHMH 17 Rev 1/2001

ORIGINAL

		Registrar		Cert	tment of Health an ificate of Death	Reg	g. No.	0131
Physic	ian	Decedent's Name (First, Middle Russell	W.	Arnold	Cr.	2. Date of Death Month	Day Year	Time of Death
/Med		4a. Facility Name (If not institution			Sr. 4b. City, Town, or Location of D		8, 2004 4c. County of Death	17:15
Exami	ner	MEMORIAL HOSPI			CUMBERLAND		ALLEGANY	
Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. (Month, Day,	9 Birtholage	(State or Fore
Director		212-24-2494 Usual Residence of Decedent	1 ⋈ M 2□ F	76 Yrs.	MOILIS Days Floors	Min. (Month, Day,) Aug 3,	1927	V
Marylan f ehow led el	ō	MD 10b. County	gany	10c. City, Town or Loca Cumb				Inside City Limi 1 ☑ Yes 2 ☐ N
or 28a-	Funeral Director	10e. Street and Number			10f. Zip Code	100	g. Citizen of What Country?	
s 23s	E a	318 Penn Aven		dept Ever in II S 13 W	21502	2/5-2-1/-	USA	ndian
o within 72 hours after death with the Maryland piene. r than "natural", or Items 23a or 28s-f show the Medical Examinat insafter multiped at	þ	11. Marital Status 1 □ Never Married 2□ Marr. 3 □ Widowed 4 ☑ Divorced	Armed Fore	2 XNo	as Decedent of Hispanic Origin res, specify Cuban, Mexican, P Yes 2 No Specify:	(Specify Yes or No- Puerto Rican, etc.)	14. Race - American I Black, White, etc. Specify: white	ndian,
n "natur	Completed	15. Decedent (Specify only highes	t grade completed)	(Give ki	nt's Usual Occupation nd of work done during most of NOT use retired)	f working	Sb. Kind of Business/Indust	ry
	Ho	Elementary/Secondary (0-12)	College (1-	laborer			teel Company	,
ould be filed Mental Hygid arked other atic event,	Be	17. Father's Name (First, Middle, John G. Arno				Name (First, Middle, Ma		
and and is m	To	19a. Informant's Name/Relationsi Lewis Arnold		19b. Mailing n 100 A	Address (Street and Number of Auburn Avenue			, 21502
Tan Heali em 2 thar		20a. Method of Disposition		20b. Place of Disposit			Oc. Location - City or Town,	
2 5 5 2 2 A		1 ☐ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Si	pecify)	Davis Memo	rial Cemetery		Cumberland	MD
permit. Pag Department Important: any injury o		21. Signature of Funeral Service I	2 Aern	Mi 22.1	Scarpelli Funera 108 Virginia Ave	l Home, PA	nd MD 21502	
7		23a. Part1. Enter the disease, or shock or heart failure. List	complications that ca	used the death. Do not enter			t. Apr	proximate erval Between
 nysician		Immediate Cause (Final disease or condition			PATIC METASTAS	SIS AND	On:	set and Death EAR
/Medical Examiner		resulting in death)	Due to (o	or as a consequence of):				
-xammer		Sequentially list conditions.	b. ———	METASTASIS				
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Bain certificate be executed attending physician and for use as the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (o	or as a consequence of):				
shysici the bu	dlcai		d					
ding p	/Med	IF FEMALE:	23c If yes outco	ome of pregnancy				
y the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	th 2 Fetal death 3 E int at time of death 5 C	ctopic pregnancy Other (specify)		23d. Date of delivery Month Day	Year
signed b	þ	Part II. Other significant condition	ns contributing to dea	ath but not resulting in the und	erlying cause given in Part I.		cco use contribute to the ca	
been s	eted						2 No 3 Probably	4 Unknov
ate has	Completed					24a. Was an autopsy performe		tion of cause of
this certificate	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		05.00	Death (Check only one)		
	J: To	27. Manner of Death	28a. Date of		28c. Injury at	ng Home 5 Residence		
r death. ector: After	atior	1. ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
s after death	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 289. Place o	of Inju ry - At home, farm, stree g, etc. <i>(Specify)</i>	t, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Rou State)	ute Number,
within 24 hours after CTO the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying (Check only one)	g Physician: To the be Examiner: On the bas and manne	sis of examination and/or inves	ccurred at the time, date and platigation, in my opinion, death o	lace, and due to the caus	se(s) and manner as stated and place, and due to the	cause(s)
within 24	Me	29b. Signature and title of certifier	1	/	29c. License number	29d	. Date signed (Month, Day,	Year)
		· 1/1/	al)	As	D35481	5	anuary 9th	2004
	1 1	30 Name and address of person	who completed cause	of death (Item 23a) (Type, Pr	· · · · · · · · · · · · · · · · · · ·			
	ļi	SAGIN, MARK A.			ENUE, SUITE 40			

		1_ For State	Type or Print in State of Maryla	nd / De	·	Health and M	-	•	e. N. 01313
		Registrar			eniicate oi	Death	2. Date of Deat	g. No.	4 01012
Physici	an	1. Decedent's Name (First, Middle, Las	ALLE	11			Month JANUAR	Dav Ye	3. Time of Death 04 9:25 AM
/Medi		4a. Fecility Name (If not institution, give		//	4h City Town	or Location of Death		4c. County of 1	
Examir	ıer		CALTH CARE	SVSTE		POINT		CECIL	
Funeral		VA MARYLAND HE 5. Social Security Number 6. Se				If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
Director		169-32-0814 1	M 2□F 65	∠ Yrs	Months Days	Hours Min.	(Month, Day,	30/1939	Country)
D		Usual Residence of Decedent					The state of the s		
arylan	_	10a. State 10b. County		City, Town or	Location				10d. Inside City Limits
Be-f	Director	PA, LANCA	STER	NO	TIINGHA	m			1 ☐ Yes 2 No
ith the Ma or 28e-f	Dire	10e. Street and Number	1 0-15		10f. Zip Code	2/2	11	Og. Citizen of Wha	it Country?
of E.E.E. Cooks after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Other than Insturel; or Items 23s or 28e-f show ent, the Medical Examiner must be matified at	Funeral		IN ROAD		143	162		U.	S. A.
ler dea	nu	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
rs aff	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 A Yes 2 □ No If Yes, Give Year or Dates: /966	-69	1 ☐ Yes 2 No	Specify:		Specify:	11617=
72 hours natural',	ed	15. Decedent's Ed			cedent's Usual Occup	pation		16b. Kind of Busin	ess/industry
within 72 h giene. In then netu	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed)	(G	ive kind of work done e. DO NOT use retire	during most of work	ting		
d within giene. ir then	E	12 (0-12)	College (1-4or 5+)		SALE	-5		AUTO.	MOTIVE
be filed Ital Hyg od other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
uld be Mental rrked c	ToE	WILLIAM	E. ALLE,	N		MARTI	4A RA	E 056	PORNE
2 should be filed with and Mental Hygiene. Is marked other than eumatic avent, the M		19a. Informant's Name/Relationship (T			ailing Address (Street	and Number or Rui	al Route Number,	City or Town, Sta	te, Zip Code)
s 1 and 2 should f Health and Men item 27 is marke other treumatic		BARBARA ALL	EN-WIFE	3	70 BROW	WRD-1	611116-1	in pa.	19362
permit. Pages 1 and 1 Department of Health Important: If Item 27 any injury or other fr		20a. Method of Disposition 1 ™Burial 2 □ Cremation 3 □		Place of Discemetery, of	sposition (Name of crematory or other place	ce)	Date 3004 2	20c. Location - City	or Town, State
Pages nent of ant: If its		*4 □ Donation 5 □ Other (Specify		XFOR	D CEMETH	THE JANSIA	1217	OXFOI	RD, PA.
permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Licens	See ,		22. Name and Addre	of Facility	227	PENN G	113
B T T T T T T T T T T T T T T T T T T T	0. 3	Edwar M	geown-	1	BUFFER	Spelt -	0115	D. FA.	19363
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de one cause on each line. a. METASTAT Due to (or as a conse	IC LI			or respiratory arre	est,	Approximate Interval Between Onset and Death UNKNOWN
executed in and iai-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	b. Due to (or as a conse	equence of):					
Pur Be		resulting in death) Last	Due to (or as a conse	equence of):					
ne death ce the attendi hed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3 □Ectopic pregnancy 5 □ Other (specify) _	r		23d. Date of Month	delivery Day Year
uires that the signed by Id be detac	þ	Part II. Other significant conditions co	entributing to death but not re	sulting in the	e underlying cause giv	en in Part I.			e to the cause of death? Probably 4 \(\sum_{\text{Unknown}} \)
w requir been s	lete						24a. Was an	24h Wass	autopsy findings available
	e Completed	25. Was case referred to medical			1		autopsy perform 1 Yes 2	prior deat	to completion of cause of h?
ysician: is certific director.	O B	examiner?	Hospital: 1X Inpatient 2[TER/Outpat	tient 3 DOA Oth		h (Check only one	nce 6 Other (S	Daniel 1
Phy Prise	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Injur		28d. Describe hor		эрөсту)
nding t tth. : After e funer	ig l	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injur		k? Yes 2 □ No			
Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certificeting filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm,	street, factory, office		28f. Location (Str. City or Town,	eet and Number of State)	r Rural Route Number,
To the Hospitel within 24 hours a To the Funeral E completely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, de nation and/or	eath occurred at the tir investigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
To the within. To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (M	onth, Day, Year)
10		12	0.11	5.	1	OEDET	тт.т	ANUARY I	14.2004
KI		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Typ	oe, Print)	103130	OL UE	MOUNT .	1. 1/2003
P			AR, M.D., VA			TH CARE	SYSTEM	PERRY	POINT, MD
Sta Registr		31. Date filed (Month, Day, Year), JAN 21 20	32. legistrar's Sign	nature	frest		,		

			1- For State of Maryland / Depart Registrar Certif	tment of Health and Me ificate of Death		ene 2004	01314
	Physici		1. Decedent's Name (First, Middle, Last) Mary Louise Bowling		2. Date of Death January	Pay 2004 Year	3. Time of Death 9:55 A M
	/Medic Examir		Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert C	ounty
	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, Y March 11	• 1908 Wes	lace (State or Foreign try) t Virginia
	e Maryland e-f show illied at	ctor	OH Jackson County Jackson OH Jackson County Jackson	tion		1	0d. Inside City Limits 1 □ Yes 2 No
	th with the 23e or 28	al Director	10e. Street and Number 120 Anderson Drive	10f. Zip Code 45640	10g	Citizen of What Cour	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic avant, the Medical Examinational be notified at ance.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 覧 No	as Decedent of Hispanic Origin? (Spec 'es, specify Cuban, Mexican, Puerto R Yes 2XNo Specify:	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	within 72 ho ane. than "natur be Medical I	Completed by	(Specify only highest grade completed) (Give kir life. DO	nt's Usual Occupation nd of work do ne during most of working NOT use retired) Representative	9	b. Kind of Business/Ind	
	uld be filed v Aental Hygie rked other i tic avant, II	To Be Co	17. Father's Name (First, Middle, Last) William Albert Lilly	18. Mother's Name (Laura L.	(First, Middle, Ma.		510
, Maryland	and 2 shou alth and N 127 ia ma ar trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Journey Drive, Owi	Route Number, C		
Baltimore,	Pages 1 ament of He ant: If itam ury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, cremating Highland Methods 1.	emory Gardens Jan.	7, 204	c. Location - City or To	W.V.
Balt	permit. Depart Import any inj		Michael W. Lag. 812	Name and Address of Facility Lee 25 Southern Maryla	and Blvd	., Owings,	MD 20736
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner	ē	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury) August 100 (or as a consequence of): August 100 (or as a consequence of): August 100 (or as a consequence of):			(years
8760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	hitis living		i	lays
P.O. Box 6	that the death certific ed by the attending p detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 meths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec	ctopic pregnancy hther (specify)		23d. Date of delive Month	ry Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the under right that a mic in farct	erlying cause given in Part I.	23e. Did tobac	co use contribute to the	
II Reco	The law requisate has been page 2 should	Completed			24a. Was an autopsy performed 1 Yes 2 🖺	prior to cor death?	psy findings available appletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The lar within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (3 DOA Other: 4 Nursing Home 28c. Injury at Work? M 1 Yes 2 No		e 6 ⊡Other <i>(Specif</i> y injury occurred)
Divis	ital or Atters as after desat Diracto	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office 28	If. Location (Stree City or Town, S	t and Number or Rura. Itate)	Route Number,
	To tha Hospital or within 24 hours after the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invession and manner stated.	tigation in my opinion, death occurred	at the time date	and place, and due to	the cause(s)
7	Twill will	_	29b. Signature and title of certifier Mo hospitalist	29c. License number 0 60390 nt) Arince Fred	290.	Date signed (Month, 1) $1/02/2$	004
	15 Sta	to	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Adleh Tuber 100 Hospital 1 31. Date filed (Month, Day, Year) 32. Registrate Signature	d. Prince Fred	erick,	mg 20	678
	Registr		JAN 0 5 2003 Resear &	Coule			

		-	For Stete Registrar	State of Ma	rylan		artmen rtificate				-	giene Reg. No.	2004	01315
	Physici /Medic	al	Decedent's Name (First, Middle, La	V .				rook			Date of De. Month Janual	ry 2	Year 200 County of Dea	
	Examin Funeral Director	ŭ	3939 Seaside 5. Social Security Number 6.3	Court Apt		08 last birthday) Yrs.	Nor	th E		h	Date of Birt (Month, Da		Calv	
	h the Maryland r 28a-f show	Irector	Usual Residence of Decedent 10a. State 10b. County	•			th B	Code					zen of What Co	10d. Inside City Limits 1 1 Yes 2 □ No puntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumetic event, the Modical Examinar must be incitified at an once.	To Be Completed by Funeral Director	3939 Seasid 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 1 1 1 1 1 1 1 If Yes, Give Year or Dates:	ver in U	.S. 13.	Was Deced If Yes, spec		spanic Or n, M exica		fy Yes or No can, etc.))- 1	USA 14. Race - Ame Black, Whi Specify: B1	te, etc.
21215-0036	ed within 72 hour giene. er than "netural", the Wooleal E.	Sompleted b	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12) 1 2	ducation	+)		dent's Usua kind of wor DO NOT us Sing	rk done d se retired) ASS	uring mos Sist			Nur		Undustry Center
Maryland	nould be file I Mental Hy narked oth netic event	To Be (17. Father's Name (First, Middle, Las Melvin	N	ewt		•		Ma	nilla			Mas	
	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship Pamela Newton 20a. Method of Disposition	/Daughter	20b. F	364 Place of Dispo	Fair	grou ne of	ınd	Road Dat	Prin	ce F	Town, State, 1 reder	ick,MD2067
Baltimore,	srmit. Pages epartment of oportent: If it ny injury or o		1 Burial 2 □ Cremation 3	ify)		rd's	UMC	Cem.	•		/2004 311 F		ings,	MD me d.,MD20678
68760,	that the death certificate be executed Sed by the attending physician and detached for use as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	e. Consequence Consequence Consequence	uence of): uence of): uence of):	Lancv		g, such as	s cardiac or r	espiratory au	rrest,		Approximate Interval Between Onset and Death & (Jew)
.O. Box	t the death certifica by the attending ph ached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Feta	Ideath 3]Ectopic pr] Other <i>(sp</i>				·	2	3d. Date of de Month	livery Day Year
Records, P	e law requires has been sign je 2 should be	Completed by P	Part II. Other significant conditions	contributing to death bu	it not res	ulting in the u	nderlying c	ause give	n in Part	1.	1 🗆 Y	Yes 2€ an	3No 3□P	o the cause of death? robably 4 □Unknown utopsy findings available completion of cause of
Division of Vital Records,	ng Physicien tter this certifi neral director	Certification; To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 2 Accident investigate 3 Suicide 6 Could not determined	be age Place of Init	Year) Iry - At he	28b. Time o Injury ome, farm, str	f 2	8c. Injury Work 1 □ Y	I ^{C.} 4□ N	ursing Home 28	1 Yes Check only of 5 Resided. Describe I	2 No	1 Yes	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co		hysicien: To the best of miner: On the basis of and manner sta	examina		vestigation	, in my op c. License	inion, de	ath occurred	at the time,	date and 29d. Date		th, Day, Year)
	6		30. Name and address of person who Kenneth L All off	110 Ham	bet 12	oad Su	Print)		· '		ck M			
	Sta Regist		31. Date filed (Month, Day, Year)	6 2003	Page	· K	Ana	260 8						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		l / Depa		t of H			tal Hygi	ene2 () () (;	0 3 6
			1. Decedent's Name (First, Middle, Last)								ate of Death	Day Year	3. Time of Death
	Physici /Medio		Bobby Joe Brown									4, 2004	6:52 P ^M
	Examir		4a. Facility Name (If not institution, give s	reet and number)			4b. City,	Town, or	Location of D		•	4c. County of Dea	th
			Union Hospital					E1kt				Ceci1	
	Funeral Director		5. Social Security Number 6. Sex X	7. Age M 2□ F	(In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	Hours	Min. (/	ate of Birth Month, Day,		thplace (State or Foreign west.
	D		Usual Residence of Decedent		100 City	Town or Lo	action			1.56	ptembe	=1 11/11/2	111911110
	Manyla f ahov	Jo.	MD Cecil			kton	Callon						10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1
	r 28a-	Director	10e. Street and Number			N.COII	10f. Zip	Code			10	g. Citizen of What Co	ountry?
	h with	a D	100 Laurel Drive				21	921			τ	JSA	
	deat	Funeral		2. Was Decedent E Armed Forces?	ver in U.S	. 13.	Was Deced	ent of H	spanic Origin n, Mexican, P	? (Specify `	Yes or No-	14. Race - Ame Black, Whit	
Maryland 21215-0036	y within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f ahow the Medical Examinar must be rodified at	5	1 Never Married 2 Married 3 Widowed 4 MDivorced	1 ☐ Yes 20 N If Yes, Give Year or Dates:	0		1 ☐ Yes 2		Specify:		, , ,	Specify: Wh	_
5-0	72 hc "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	kind of wor	k done d	during most of	f working	1	6b. Kind of Business	(Industry
121	within ene. than	dw	Elementary/Secondary (0·12)	College (1-4or 5-	+)		ро мот us D is ab		9				
9	Hyg tha	0	17. Father's Name (First, Middle, Last)				DISan	rea	18. Mother's	Name (Firs	st, Middle, M	aiden Sumame)	
<u>a</u>	D D D	To B	Raymond Brown						Mary	Hi1da	Stout	5	
ary	and and and and and and and and and and		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address	(Street	and Number o	or Rural Rou	ite Number,	City or Town, State, .	Zip Code)
	an eal m 7		John M. Brown/Brot	her	001 01	744	Kilgo	r Co	urt, N			9702	
Baltimore,	S to E L		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval from State	Cer	netery, crer pin M	natory`or of	her plac	θ)	Date	21	Oc. Location - City or	Iown, State
Ë	permit. Pag Department Important: I any injury c		'4 □Donation 5 □Other (Specify)		Mem	orial	Park		01 ss of Facility	/08/0	14 I	Elkton, MI)
Bal	permit. Pag Department Important: I any injury o		21. Sign Mire of Fune Service License	e		A	ndrew	G.	Gee			E. Main	
			23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	ations that caused	the death.	Do not ent	unera er the mode	of dyin	me, PA	rdiac or res	piratory arres	cton, MD 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	e cause on each line	e.	- 1	1- 0		4				Onset and Death
	/Medical		resulting in death)	Due to (or as a	conseque		1- 0	4 6					
	Examiner		Sequentially list conditions, b.	CAF	7 , \	CC	DeD)					
	ed sit	Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	conse ue	ence of):							
	be executed ician and burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a	conseque	ence of):						1	
760,	0 0 0	cai	d	H18	M I	SR							
89	leath certificat attending phy I for use as th		15551115		7								
Вох	ath cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths?	3c. If yes, outcome o		death 3□	Ectopic pre					23d. Date of de	ivery Day Year
о. П	at the dea by the at tached fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of dea	ath 5	Other (spe	ecify)				, morning	Day
α.	es tha	þ	Part II. Other significant conditions con	tributing to death bu	t not resul	ting in the u	nderlying ca	ause give	en in Part I.	:	23e. Did toba		o the cause of death?
Sor	w requir been si should	etec	000							_	24a. Whas an		utopsy findings available
of Vital Records,	The lav	Completed	CIR								autopsy perform	prior to death?	completion of cause of
ta		0	25. Was case referred to medical						26. Place of		eck only one	2.10	2 NO
Į.	nysic lis ce direc	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 🗌 Inpatier	nt 2 E	R/Outpatien	t 3□ DO	A Oth	er: 4 🗌 Nursi	ng Home	5 🗌 Residen	ce 6 Other (Spe	cify)
o uo	ing After une		27. Manner of D_ath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	Year)	28b. Time of Injury	M 28	Bc. Injun Worl	vat k? Yes 2 □ No		Describe how	injury occurred	
Division	il or Attending after death. Diractor: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At hon . (Specify)	ne, farm, str	eet, factory	, office			ocation (Stre City or Town,	eet and Number or Ro State)	ura! Route Number,
	Hospita 4 hours Funarel ety fillec	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin		examination								
	To tha within 2 To the complet	Me	29b. Signature and title of certifier				29c	. License	number		296	d. Date signed (Mont.	h, Day, Year)
)	,- >F 0		1 Cobange	- 1m	>		D	00	6075	56		1/5/04	
	2		30. Name and address of person who con	mpleted cause of de		~~	Print)	223	E. M.	ain s	St. 51	trow m	B 3/92/
	Sta	ate	31. Date filed Month, Day, Year)	32 Registra								2000	//-/
	Regist		JAN 0 6 200			H A	mark s	,					

			1 - For State Registrar	State of	of Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	ealth a D <i>eath</i>	and M		giene Reg. No.	200	4 01317
			Decedent's Name (First, Middle, Las								2. Date of Dea	ath		3. Time of Death
	Physicia		Virginia Helen Bo	1kovic	h						J im war	Day	Yeer . WY	16:40 M
,	/Medic Examin		4a. Fecility Name (If not institution, give				4b. Cit	y, Town, or	Location o	f Death		4c. (County of Dee	
1		·.	58 Joy Drive					Nort!	h Eas	t			Ceci	1
	Funeral		5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Und	er 1 Year s Days	If Under 2	24 Hrs. Min.	8. Date of Birtl (Month, Day	h V Yearl	9. Bir	thplace (State or Foreign
	Director		428-30-7402	□ M 2 XX	78	Yrs.	Month	S Days	Hours	MIII.	January	16,	1925~	Mississippi
	D		Usual Residence of Decedent											
	how	_	10a. Slate 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	e Ma	cto	Pennsylvania Sch	uy1ki1	1	Saint	Clai	r						1 X Yes 2 □ No
	or 26	Director	10e. Street and Number				10f. Z	ip Code				10g. Ciliz	en of Whal Co	ountry?
	23a	ral	334 Arnut Street					1797	00				ted St	
	ems ems	Funeral	11. Marital Status	Armed F	edent Ever in U orces?	J.S. 13.	Was Dec	edent of His ecify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	. 1	 Rece - Ame Black, White 	
36	or it	핏	1 Never Married 2 Married	If Yes, G			1 ☐ Yes	2 X No	Specify:				Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f ehow int, the Medical Evantical must be notified at	d by	3 Widowed 4 □ Divorced	Year or l	Dates:	10.0					1			*
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	lled /	ပိ	12 17. Father's Name (First, Middle, Last)			MI	anag	er	18 Mothe	r's Name	(First, Middle,		ood Se	rvices
and	12 should be filed within "h and Mental Hygiene. 7 le marked other then "r raumatic event, the Me."	Be											arramo,	
3	d Me d Me nark natic	ဋ	John Ervin 19a, Informant's Name/Relationship (1)	Tuno Printi		10b Mailie	an Addra	nn /Stroot o			Dean I Route Numbe	e City or	Tourn State	Zin Codo)
Maryland	12 st h and 7 te r		The second secon											
	of Health of Health litem 27		Judith Murphy/Daug	gnter	20b. 1	Place of Dispo			NOFE		st, Mar		ation - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.		1 X Bunal 2 ☐ Cremation 3 ☐		State	cemetery, crei	matory or	rother place	J		ry 6,			
Ħ	tmer tant njury		* 4 □ Donation 5 □ Other (Specifical Service Licental Se	1 //	Ho1	y Trin				2004				r,Pennsylvan
3al	permit. Departr Importa eny inji		21. Signature of Funeral Service Lices								uch Fun			1 1 01001
	40 E e d	127 South Main Street, North 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest.										st, Ma		
			shock, or heart failure. List only	one cause on	each line.	th. Do not ent	ter the m	ode of dying	J, such as	cardiac d	r respiratory ar	rest,		Approximate Interval Between Onset and Death
}	Physician		Immediate Cause (Final disease or condition	e or condition a. I right eral Vascular Visease									1/ears	
	/Medical Examiner		resulling in death)	Due to	(or as a consec	quence of):								,
2	LXammer	_	Sequentially list conditions,	b	ASC	ND								Years
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	and and -tran	кап	that initiated events resulting in death) Last	C. Due to	(or as a consec	ruence of):			 					
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8760,	sate b	dical		d										
9	leath certific attending p	Me	IF FEMALE:	020 16 1100 01	steeme of progra	2001								
Вох	ath cuttencor us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					2	3d. Date of de Month	livery Day Year			
-	the a	sic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Preg 9□Unki		death 5	_l Other (specify)						
P.O.	that the death cer ed by the attendir detached for use	P.	Part II, Other significent conditions of	ontributing to	teath but not re-	eulling in the u	nderhing	Called Cive	on in Part I		23e Did to	phacco us	e contribute to	the cause of death?
ŝ,	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	Completed by	Part II. Other significant conditions c	online atting to	Joan Dui Hoi 16.	saming in the a	i i deriyii ig	Cause give	HIBE CALL.		12X Y			robabiy 4 □Unknown
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ec	law lasb	nple									24a. Was autop	SV	prior to	topsy findings available completion of cause of
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?							of Death	(Check only o	пе)		Delta
£	S S D	ို	1 ☐ Yes 2 💢 No		Inpatient 2			_	4 (140		me 5 Resid		Other (Spe	city) Residen
u	ng P	:uo	27. Manner of Death 1 1 Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o Injury		28c. Injury Work	:?		28d. Describe h	iow injury	occurred	
sio	Attending or death. ector: After by the funer	cati	2 Accident investigation				М		res 2 1					
Division of	pr Att	ij	3 ☐ Suicide 6 ☐ Could not be determined	200. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, sti rfy)	reet, facti	ory, office			28f. Location (S City or Tow	street and m, State)	Number or R	ural Route Number,
	27. Manner of Death 1 Canatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Rur													
	To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								s stated. s to the cause(s)				
	the the	Wed	one) 29b. Signature and title of certifier	and ma	nner stated.			9c. License	number			29d Date	signed (Mont	h Day Year)
	S S S			1.	0.2			_	53	14	1			
				Ros, 1				יע	つ)	17		1 000	7	3,2004
	0		30. Name and address of person who						1	13				
			It ray leas, MD	Union	Registrar's Sign	1, 511	210 /	1, 1	7 21	741				
	Sta Registi		31. Date filed (Month, Day, Year)	nn/ 32.	negistrar s Sign	A So	See all	P. Carrier						

		1 - For State Registrar	State of Marylan	d / Depa	artment of H	ealth and	Mental Hyg	iene 19. No. 2004	01318	
/Me	sician edical miner	4a. Fecility Name (If not institution, giv	GURA e street and number)		4b. City, Town, or	Location of Dea	2. Date of Deat Month JANUES	Day Year 2004 4c. County of Death	3. Time of Death A	
Funer Direct		5. Social Security Number 219-67-9500 Usuel Residence of Decedent		la <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 1925 Sier	place (State or Foreign ntry) ra Leon	
the Maryland 28a-f show	Director	10a. State 10b. County	Top on La	y, Town or Lo			11	0g. Citizen of What Cou	10d. Inside City Limits Yang Yes 2 No	
1215-0036 within 72 hours after death with the Maryland ene. than 'natural', or Itama 23e or 28e-1 show than in a Majisal Expring a manule or pulling a	by Funeral Di	8 Z 1 6 DELLWOOD CO 11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent Ever in U.S. Armed Forces?		20706 Was Decedent of Hi If Yes, specify Cuba			U.S.A. 14. Race - Americ Black, White,	can Indian, etc.	
N 255.	Completed	15. Decedent's Ei (Specify only highest gra Elementary/Secondary (0·12) 12th	Jucation (de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of wi	orking	16b. Kind of Business/In	·	
Maryland 2 Id 2 should be lifed to 2 should be lifed to 3 should be lifed to 3 should Hygie 27 is marked other?	Be	17. Father's Name (First, Middle, Last,		10b Mailin	on Address (Street s	AMINA		•	Codo	
	8	CHARLES BANGURA/	SON 20b. P	8216	DELLWOOD sition (Name of matory or other place	COURT G	LENARDEN,	MARYLAND 2 Coc. Location - City or To	.0706	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item		1X Burial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service Licer	y) GE(ORGE WA	ASHINGTON	1-7-		ADELPHI, MARY		
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(760, te be executed Exysteian and Experience)	lcal Examiner	cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):						
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Kecords, Phe law requires that e has been signed bige 2 should be deta	Ď	Part II. Other signmeant conditions of	contributing to death but not res		co use contribute to the cause of death? 2 No 3 Probably 4 Hiknown					
- 10 14	Com							prior to co death? 1 Yes	psy findings available mpletion of cause of 2 No	
	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatier	t 3 DOA Othe	A.C.	Home 5 Decide			
	_ ⊢		27. Manney of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined between the court of the country of					5 Residence 6 Other (Specify) d. Describe how injury occurred		
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-(4)		30. Name and address of person who SA(VA) Name and SA(VA) SA(VA)	* ~	1505	Print)	Drive	, Chev	ely Mo	my land	
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		-	Registrar 1. Decedent's Name (First, Middle, Last)			imodio or Bo	1	2. Date of Death		3. Time of Death																
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		.cı	Frederick Memoria	1 Hospital		Frederi			Frederi																	
	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (<i>In yrs. last</i> 83			Under 24 Hrs. ours Min.	8. Date of Birth Month, Pay, OCT 9,	1920 Mar	hplace (State or Foreign untry) yland																
	pu 🔉		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Lo	cation		_		10d. Inside City Limits																
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	th with th	ai Dire	317 Queen Street			10f. Zip Code 21	701	10	g. Citizen of What Co U.S.A.	untry?																
36	filed within 72 hours after death with the Maryland Hygiene sther than "natural", or Itams 23a or 28a-f show shy, the Medical Exas ill verritual be trydified at	by Funeral Director	11. Marital Status 1 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	i	Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spe exican, Puerto I pecity:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.																
Ö	fural'	ed p	15. Decedent's Educ	Year or Dates:	I6a Deced	ent's Usual Occupation		1	8b. Kind of Business/	Industry																
1215	uithin 72 ne. han na	Completed	(Specify only highest grade	completed)	(Give :	kind of work done during DO NOT use retired) tor/Guidan	g most of workir	g	Public Ed	•																
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic svant, the Medical Examination and once.	To Be Co	17. Father's Name (First, Middle, Last) Coleman		debra		Mother's Name	(First, Middle, M		elser																
	nd 2 shou lith and M 27 is mar	F	19a. Informant's Name/Relationship (Type H. Scott Bell/Son	pe, Print)		g Address (Street and I Layla Drive																				
	s 1 ar		20a. Method of Disposition	come	e of Dispos	sition (Name of natory or other place)	D	ate 2	Oc. Location - City or	Town, Stete																
	Pages ment of ant: If it ury or o		12 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State Mt O	livet	Cemetery .	Jan 12,	2004 F	rederick,	Maryland																
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.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan/	ysiclan	ysiclan/	ysiclan/	ysiclan/	ysiclan/I	ysiclan/	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
s, P	s that ned b		Part II. Other significant conditions conf	tributing to death but not resulting	ng in the un	derlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?																
rds	equire en sig vuld bi	ed by	q pa	q pa	q pa	ed b	A/zhyime	C) Dym	en	19		1 ☐ Yes	2 3 No 3 Pro	obably 4 Unknown												
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<u> </u>	The cate h page	Com						performe	death?	2□ No																
Vita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:	in .		Place of Death	(Check only one,																		
o	Phys this ral dir	. To	1 Yes 2 240	1 Inpatient	Outpatient	28c. Injury at		e 5 Residen	ce 6 Other (Spec	city)																
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Division of	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	a, farm, stre	m, street, factory, office 28f. Location (Stre City or Town,			et and Number or Rural Route Number, State)																	
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	To the I	Me	29b. Signature and title of certifier	6/1.	~	29c. License nur		290	d. Date signed (Month	n, Day, Year)																
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(They		30. Name an address of erson who cor Casper E. Cline,	n, eted cause of death (Item 23			reet F	rederi ob	Maryland	21701																
3	Sta	te	31. Date filed (Month. Day, Year)			Janes Vincer St.	rule F	CUCLLUK	, IRILYLAIR	41/01																
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				State of Maryland	/ Depa		lealth and l	Mental Hyg		_	01320	
ì	Physici		1. Decedent's Name (First, Middle, Last)	d Bar	ber	Month	2. Date of Death Month Day January 6, 2004		3. Time of Death 2:53 P. M			
	/Medic Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, o	Location of Deat			ounty of Deat		
			Crofton Convalesce	ent Center		Croft				nne Art	ındel	
I	Funeral Director		5. Social Security Number 577-26-5752 G. Sex 1 M 2 S F 85 T. Age (In yrs. last birthday) 1 M 0 ths Days Wonths Days Hours Min. Jan. 28, 1918							9. Birt Co Vir	hplace (State or Foreign untry) ginia	
	land		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits	
death with the Maryland	Mary	tor	Md. Prince Ge	eorges B	owie						1 Ty Yes 2 □ No	
	or 28g	Funeral Director	10e. Street and Number			10f. Zip Code			l0g. Citize	n of What Co	ountry?	
	ath wi	ral	14997 Health Cente	er Drive			20716		USA			
	er de	une		 Was Decedent Ever in U.S. Armed Forces? 	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14	. Race - Ame Black, White		
5	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 👿 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		S	рөсify: Wh	ite	
ž Ž	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or lieme 23e or 28e-1 show event, it a Madical Examinar instal be notified at	ted	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup	ation		18b. Kind	of Business/	Industry	
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E 2 2	T = 0 ()	To Be	17. Father's Name (First, Middle, Last)	Kent Jones			Ka	ne (First, Middle, Maiden Sumame) atherine Iverson Vernon				
Ma	(4 10		19a. Informant's Name/Relationship (Type Robert A. Wright			ng Address (Street						
	1 and Health em 27		20a. Method of Disposition	20b. Pla	ce of Dispo	She1by I				e, Md.		
Baltimore,	Pages nent of int: If It iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	netery, cren	natory`or other plac Memorial		12.04		ille,		
	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lights	mo N		. Name and Addre	14.5-10-1	eall Fund				
ñ	99 5 9) Jan	Drall	(5512 N.W.	Crain H	wy., Bow	ie, M	Id. 207	15	
	Physician		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition		Approximate Interval Between Onset and Death 1 day							
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	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to for as a monsacilla	nipa ory:							
	be executed ician and burial-transit	xar	resulting in death) Last Due to (or as a consequence of):							-		
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Q Q	feath certificate t attending physic ifor use as the b			111								
ROX	th cer tendir r use	an/N	230. Was decedent pregnant	c. If yes, outcome of pregnand 1□Live birth 2□Fetal d		Ectopic pregnancy			230	d. Date of deli	•	
	ie dea the at hed fo	Physiclan/Med	in the past 12 months? 1 Yes 2 XNo 9 Unknown	4☐Pregnant at time of dea 9☐ Unknown	th 5 🗆	Other (specify)				Month	Day Year	
ī.	hat the ad by th detache	Phy	Part II. Other significant conditions cont	ributing to death but not result	ing in the ur	nderlying cause give	an in Part I	23a Did tol	acco use	contribute to	the cause of death?	
cords,	w requires that the de s been signed by the a should be detached f	ted by	Coronary arter		23e. Did tobacco use contribute to the cause of c		bbably 4 Dunknown					
ပ္သ	> Q 76	Completed	Hyperlipidemia					24a. Was a autops	y	prior to c	topsy findings available ompletion of cause of	
E .	cate has page 2 :	Co	Hypertension					perform 1 🔀 Yes 2		death?		
VIII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		. all pos Othe		th (Check only on				
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0	Attending Ph ir death. ector: After th by the funeral	tlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Worl	(? Yes 2∐No		28d. Describe how injury occurred			
DIVISION	l or Attendii after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St City or Town		lumber or Ru	ral Route Number,	
5	ital or rs aft ral Dii led in	Cer		building, oto. (opoony)				Only of Your	, Siale)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	cien: To the best of my knowled: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	and due to the carred at the time, da	ause(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)	
	To t withi To tl	X	29b. Signature and title of certifier	4		29c. License		2	9d. Date s	igned (Month	, Day, Year)	
)	(> 8/1/ (lt	u MD		D.	52139	(01-08	-04		
/	9		30. Name and address of person who con Seial G. Mattu MD					0				
7	Sta	-	Sejal G. Mattu MD 31. Date filed (Month, Day, Year) JAN 0 9 2004	32. Registrar's Signatur	Θ		iite 220,	<u>Gambril</u>	ls, l	Md. 21	054	
-	Registr	ar	V J 2004	Beach &	2004	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 2004 8:40 AM Raymond Edward Bowers, Jr. January /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Julia Manor Health Care Center Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign March 1, 1914 Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√ M 2□ F Months Days Hours Yrs 89 214-10-1932 Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manyland Depertment of Health and Mental Hydiene. Important: If them 27 is marked other than "natural; or items 28s or 28s-f show any injury or other traumatic event. the permitted of the contract of the contrac 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits Frederick Middletown 1 ☐ Yes 2 No Maryland Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3096 Lockwood Drive 21769 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tool and Die Maker Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Edward Bowers, Sr. Margaret Dutrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mrs. Ruth E. Bowers, wife 3096 Lockwood Drive, Middletown, MD 21769 20a. Method of Disposition

12 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date Mount Olivet Cemetery, Jan. 10, 2004 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Lidensee MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Prostate Cancer 10 yrs. Examiner Due to (or as a consequence of): Physician/Medical Examiner 15 yrs. Coronary Artery Disease Attending Physician: The law requires that the deeth certificate be executed use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown à To the Hospital or Attending Physician: The law requires the within 24 hours effer death.

Within 24 hours effer death.

Car Funerel Director: After this certificete hes been signe completely filled in by the funeral director, page 2 should be. 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Tes 2XXV0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 A Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🖒 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 52323 January 7, 2004 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Khalid M. Waseem, M.D., 19414 C Leitersburg Pike, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

2 1 2004

1-	For State Registrar			
1. D	ecedent's Name	(First,	Middle,	Last)

2. Date of Death

	ı	Fun	era	a Ol
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show	any injury or other traumatic event, the Medical Exact that must be notified at	CUCB

death certificate be executed

The law requires that the

or Attending Physicien:

has

certificate

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After

Director

within 24 hours a

the

Division of Vital Records, P.O. Box 68760,

Month Dev Year **Physician** JAN. 2004 2:45 A BUTLER ANNIE ROBERTA /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner LAUREL PRINCE GEORGES LAUREL REGIONAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Months Days Hours 1 ☐ M 2 💢 F Yrs. JULY 9, 82 1921 VIRGINIA 226-26-3759 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 Yes 2 □ No Directo PRINCE GEORGES LAUREL MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707 U.S.A. 7700 CHERRY LA. #220 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ 3 ¥ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROBERTA SLACK SR. ANNIE PAYNE **JAMES** 0. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 940 FEATHERSTONE ST., GAITHERSBURG, MD. 20878 WAYNE BUTLER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 1-6-2004 BRENTWOOD, MD. 21. Signature of Funeral Service Lipensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A MO0091 | 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician SEPTICEMIA** /Medical Due to (or as a consequence of): Examiner **HYPERTENSION** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ATRIAL FIBRILLATION physician ar s the burial-t Due to (or as a consequence of) ian/Medical as by the attending gached for use as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Physic 9 Unknown 9 Unknown s been signed by the should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown CELLULITIS RT. LOWER EXTREMITY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 Yes 2X No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1X Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0052075 JAN. 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

14201

Registrar's Signature

KUKRETI, M.D.

JAN 0 5 2004

31. Date filed (Month, Day, Year)

LAUREL PARK DR. #221, LAUREL, MD. 20707

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours a

To the Funeral C

completely filled State Registrar

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 3503 Perry St. Mt. Rainer, Maryland 20712 Raman Tuli

31. Date filed (Mo. (Month, Day, Year) N 0 9 2004

32. Registrar's Signature 1 April

1X Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

29a. Certifier (Check only one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5,_ 2004 11:11a^M January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Montgomery 01nev If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. 3/26/1916 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🛣 F North Carolina 87 Director 242-09-0306 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Prince Georges Mt. Rainier, Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 United States 3001 Queen Chapel Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ☐ Widowed 4 ♣ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Maid 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Chambers 0 Glen Steward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Queen Chapel Rd. Mt. Rainier, Md. Lee Steward / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Washington National Jan. 12,2004 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope Funeral Homes
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final SPIRATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEHYDRATIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed detached for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown royou Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2☐No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 Homicide within 24 hours a To the Funeral I completely filled 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number D0058962 January 7, 2004 30. Name and didress of person who completed cause of death (Item 23a) (Type, Print)
Shashank G. Patel, M.D. 2309 Shorefield Rd. Wheaton, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2004 Registrar

		1 - State of Maryland / Department Certification	nt of Health and M te of Death	lental Hygien	21101 01225
Physici /Medio Examir	al		Town, or Location of Death		County of Death
Funeral Director		Doctors community needs at	nham r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year Oct. 19, 1	9. Birthplace (State or Foreign Country) West Virginia
the Maryland 28e-1 show notified at	rector	Md. Prince Georges 10c. City, Town or Location Bowie	p Code	10g. C	10d. Inside City Limits 1 △ Yes 2 □ No itizen of What Country?
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentat Hygiene. Item 27 is marked other than "naturat", or items 23a or 28e-1 show other traumatic event, the Madical Examiner must be notified at	by Funeral Director	1 □ Never Married 2 □ X Married 1 □ Yes 2 □ No	20715 Ident of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 🖾 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
d within 72 hour giene.	Completed b	15. Decedent's Education (Specify only highest grade completed) Flementary(Secondary (0-12) College (1-4or 5+)	nal Occupation ork done during most of works ise retired) borer	ring	Cind of Business/Industry
and yearlo Z. I. S. Should be filed with and Mental Hygiene is marked other the aumatic event, the harm	To Be C	7.77	s (Street and Number or Rura		Bragg or Town, State, Zip Code)
5 85 = P		Martha E. Cunningham - Wife 4006 Whar 20a. Method of Disposition 1		Date 20c. L	715 _ocation - City or Town, Statetimore, Md.
permit. Pa Departmer Important any injury once.			N.W. Crain Hy		
auth certificate be executed attending physician and authorities as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. End Stay Chron Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	ic obstruction	e Vulman	Onset and Death Onset and Death A A and
requires that the death certifical requires that the death certifical een signed by the attending phy hould be detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
w requires that the second of	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
The law ate has b page 2 st	e Completed	25. Was case referred to medical	26 Place of Deat	24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? o 1 Yes 2 No
ing Phy Viter this	Certification: To Bo	examiner? 1	OA Other: 4 Nursing Ho 28c. Injury at Work? 1 Yes 2 No	ome 5 Residence 28d. Describe how inju	
Hospital o 14 hours aff Funeral Di tely filled in	Medical Certif	4 Homicide determined building, etc. (Specify) 29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or investigation	d at the time, date and place,	City or Town, Star	s) and manner as stated.
To th within To th	Med	and manner stated. 29b. Signature and title of certifier MOND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D2010	29d. D.	ate signed (Month, Day, Year)
St	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	WANT FOX	LANE SI	222 MD 80715

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2:55pm_M **Physician** 2004 January 1, Kaiser Chatmon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince Georges Ft. Washington Hospital Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 249-22-1953 Yrs. Director July 16,1921 Sumter, S.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or flems 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be mortified at Maryland Prince Georges Clinton 1X Yes 2 No Directo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 9100 Pine View Ln. 20735 United States Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Montal Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic avent, the Mettle Once. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Emily Diggs Ivory Chatmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Chatmon / Son 4603 Carwell Dr. Camp Springs, Md. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 10,2004 _{Camden}, S.C * 4 □Donation 5 □ Other (Specify) Rafting Creek 22. Name and Address of Facility
Alexander S. Pope Funeral Homes
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Lice 23a. Part. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death Septicemia - UVOSEFSIS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons vuence of): Vascular acciden Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit lual Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after de-rel Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide within 24 hours after de To the Funerel Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ō To the Hospitel 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 142049 of person who completed cause of death (Item 23a) (Type, Print) MPA 31. Date filed (Month) 2. Registrar's Siggature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Pear1 01 06 2004 17:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Prince Georges Ft. Washington
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1□M 2XF Months Days Yrs 53 8-18-1950 Director 227-76-3772 Goochland, Va. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1X Yes 2 □ No Ft. Washington Maryland Prince Georges Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2201 Old Fort Hills Drive 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status filed within 72 hours after 1 X Yes 2 □ No If Yes. Give 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black à 3 Widowed 4 Divorced Year or Dates "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry HUD Housing other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Benjamin Frank Cox Pearl Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3011 Columbia Street . Richmond, Virginia, 23232 Disposition (Name of Date Moses Vernon Cox/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)

First Union Bapt. Ch. 01-10-04 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Fundortant: If ite any injury or of other. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Goochland, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service License Waula C. Back, CC 3601 3447 14th Street, N.W. Wash.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3447 14th Street, N.W. Wash., D.C. 20010 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to lor as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner (or as a consequence of): The law requires that the death certificate be executed anding physician and use as the burial-transit or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy 1 Yes 2 or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this funeral 27. Manner et eath Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Year) 1 atural 2 Accident 1 ☐ Yes 2 ☐ No Director Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire To the Hospital rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Ow Ft. Washington Hospital 11711 Livingston Road Ft. Washington, Maryland, 20744 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel J. Kleiman, M.D. JAN 0 9 2004 31. Date filed 32. Registrar's Signature State Registrar

	1 - For State Registrar	- 15		,	Department of I Certificate of		Reg.	_ 2001	+ 0132
an al	1. Decedent's Name JACK EL	e (First, Middle, La LDRIDGE C					Month January	Day Yeer 11, 2004	3. Time of Death
er	4a. Facility Name (I	f not institution, giv	re street and number))	4b. City, Town, o	or Location of Death		4c. County of Deet	h
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tor	MARYLAND	ALLEGAN	Y	FROST	BURG				1 X Yes 2 □
Director	10e. Street and Nur	mber			10f. Zip Code		10g	. Citizen of What Co	untry?
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by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 2 Married	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates:	? No	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
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		5 ☐ Other (Special	··	THE C	UMBERLAND C	-		JMBERLAND	
	21. Signature of Fu	Ineral Service Lice			22. Name and Addre	ess of Facility	6(W. MAIN	STREET
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Baltimore, Maryland 21215-0036

Diyision of Vital Records, P.O. Box 68760,

			State of Maryla				ental Hygi	ene 2001.	01320
			State Registrar	Cer	rtificate of De		Reg	g. No. 👇 🔾 🔾 🥎	3. Time of Death
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	/Medic	al	EDWIN JEROME COC	PER JR.	4b. City, Town, or Lo	ncation of Death	Januar	y 2, 2004 4c. County of Death	12:15pm [™]
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N of	Sa-f	Director	Md. Prince Georges Gr	reenbelt	10f. Zip Code		10	g. Citizen of What Cou	
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4	TS 23	Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13. 1	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec		14. Race - Amer	
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-	n = 0 5	o Be	Edwin J. Cooper Sr.			Dolly De	nnis		
Maryland 21215-0036	and Mental Is marked o	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	d Number or Rura	Route Number,	City or Town, State, Zi	p Code)
Š	alth a 27 ls		Vera D. Cooper/Wife	8437	Greenbelt	Rd. #T-2	, Green	belt Md. 20	0770
altimore,	permit: rages i and should be Department of Health and Menia Important: If Item 27 is marked any injury or other traumatic evonce.			 Place of Dispo cemetery, crer 	osition (Name of matory or other place)		ate 2	t0c. Location - City or T	own, State
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n	6		1) com X Morning	4/2/11	D538	24		anuary	2,2007
K	- (1)		30. Name and address of person who completed cause of death	(Item 23a) (Type	a, Print)	= 4/1./ 1	ATO D	o Cher	120779
1	~	ote	31. Date filed (Month, Day, Year) 2. Registrar's S	ignature	25 GKEE	NWAY	IK. DI	K. GKEEN	DELI, Ma.
	Regis	tate trar	JAN 0 8 2004	K Apa	de				2,2004 20779 BELT, Md.

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	Physicia	an .	Decedent's Name (First, Middle, La	SI)							Month	Day	Yee	er l		
	/Medic	al	Stanfor		n	Ch	ilc		Location of		Januai		200 County of De		:30	_a ^M
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	n 72 hours after death with the Maryland "natural", or Itama 23a or 28a-f show clical Experimental to notified at		35 Milkshake Lane	· · · · · · · · · · · · · · · · · · ·				403		2.00			JSA 4. Race - A	madaan la	alia a	
		Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		5. 13.	Mas Dece f Yes, sp	ecify Cuba	spanic Origii n, Mexican, i	n? (Specii Puerto Ric	y yes or No can, etc.)	-	Black, W		uları,	
36	rs att	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∀Yes 2 No If Yes, Give Year or Dates:			¹ □ Yes	2 ∑ No	Specity:				Specify:	vhite		
Ş	thou sture	ed	15. Decedent's E	ducation		16a. Deced	ient's Us	uai Occupa	ation	. 11		16b. Kin	d of Busine		,	
215	7 nic n ni	piel	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) Coltege (1-4or 5+)		(Give life. 1	kind of w	ork done d use retired	during most o	of working						
2	filed within 72 hours atter Hygiene. other then "natural", or Ite ent, the Medical Exercities	Completed	12			graph	nic a	rtist	t, sig	n sto	ore ow	ner	sigr	1 & S	ilks	creen
Maryland 21215-0036	m = 9 5	Be	17. Father's Name (First, Middle, Last	")					18. Mother:	s Name (F	First, Middle	Maiden S	Sumame)			
<u>yla</u>		၉	James Elmer Child						Lill		Α			Bel		
lar	S a a		19a. tnformant's Name/Relationship						and Number)	
	and fealth im 27 her tr		Richard A. Chilco	oat, son	20h Pi	7776 ace of Dispo			Rd., H	yatts			2078 ation - City		Itate	
Baltimore,	Pages I nent of H int: If Its iry or ot		1 ☐ Buriat 2 X Cremation 3		ce	metery, cren	natory or	other plac								
Ħ	rtmer rtant		 4 □Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		Met	ropoli			cory 0	1/06/	2004	Alex	kandri	La, VA	A	
Ba	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or other once.		21. Signature of Funeral Service Lice							Llomo	D 7	0	inaa	MD 1	2073	<i>c</i>
			23a. Part1. Enter the disease, or con	CXSS	ne death				neral				mys,	Appr	roximate	
5			shock, or heart failure. List only tmmediate Cause (Finat	one cause on each line		acte-	dir.								val Betweet and De	
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a			101	12	i work for	3(0					100	<i></i>
Н	Examiner			506 10 (01 43 4	consoqu	101100 017.										
N Jě		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	ience of):										
	od d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.												
oʻ	ate be executed sysician and he burial-transit		resulting in death) Last	Due to (or as a	consequ	ience of):										
3760,	ate be nysici he bu	licai	•	_ d			-									
68	leath certilicate b attending physic	Physician/Med	IF FEMALE:													
Вох	ath ce	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal	death 3		pregnancy				2	3d. Date of Month	delivery Day	Ύє	ar sar
_ O	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me or de	atn 5L	Other (s	вреспу) <u> </u>								
Division of Vital Records, P.O.	uires that the de signed by the a Id be detached t	Ph	Part tt. Other significent conditions	contributing to death but	not resu	ılting in the u	nderlying	cause give	en in Part I.		23e. Did t	obacco us	e contribute	e to the cau	use of de	ath?
ds,	uires sign d be	d by									10	Yes 2]No 3□	Probably	4 □Ur	nknown
00	w require been si should I	iete									24a. Was	an	24b. Were	autopsy fi	ndings av	vailable
Re	he la e has	Completed								_		rmed?	death			use of
ta	ificati or, pa	Be Co	25. Was case referred to medical						26. Place o	of Death /	1 ☐ Yes Check only	2 2 400	- 101	/es 2□!	NO	
>	ysicia s cert direct	To B	examiner?	Hospital: 1 ☐ tnpatient	2 🗆 1	ER/Outpatier	nt 3 🗆 🛭	Oth	00		5 🗀 Resi		Other (S	Specify)		
0	g Ph er th		27. Manner of Death	28a. Date of Injury (Month, Day	Year)	28b. Time of	f	28c. Injun	y at k?	28	d. Describe	how injury	occurred			
Ö	death. ctor: Alt	atlo	Naturat 5 Pending investigation	on		,,	М		Yes 2 □ N	0						
ivis	l or Atter de atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At ho (Specify	me, farm, str	reet, facto	ry, office		28	f. Location (City or To		Number or	Rural Rou	te Numb	9 <i>r</i> ,
Ω	ital o															
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: Alter this certificate has been signed by the attending phy completely tilled in by the funeral director, page 2 should be detached for use as the	Medicai		hysician: To the best of iminer: On the basis of e	xaminat										cause(s)	
	thin 2 the omple	Med	29b. Signature and title of certifier	and manner state	3 0.		2	9c. Licenso	e number			29d. Date	signed (Me	onth, Day,	Year)	
	F X F S		DOI. O 12.	CM.				5	7471			11	2/2	004		
			30. Name and address of person who	completed cause of dea	ath (Item	23a) (Tvne	Print)	49 1	0000			. /		00/		
4	+1		TI	o completed cause of decompleted CIEL	, Dono	hi	2000	u U	hert	vM	121	419				
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	s Signa	ture 1	1	acti s								
	Regist	rar	JAN	JO ZUUJ A	RISS	1 10	Jan Jan	The second second								

		•	For State Registrar	State of M	aryland /		rtment of <i>tificate of</i>		Mental H	ygiene Reg. No		01331
3	art og sa	€ ₇	Decedent's Name (First, Middle	e, Last)					2. Date of I	Death Da	y Year	3. Time of Death
	Physici /Medic	_	Livingston	Webster		Doug	an		Janua	_		8:00 P. M
)	Examin	4676	4a. Facility Name (If not institution	n, give street and number,)		4b. City, Town,	or Location of Dea	ith		County of Death	
	Najvišas aktori	4	Fox Chase Re	hab. & Nursi	ng Cent	er		er Spring			lonygome:	
数:	Funeral			6. Sex 7. A	ge (În yrs. last b	Yrs.	Months Days	If Under 24 Hr Hours Mir	. (Month, L	Day, Year)	9. Birth	place (State or Foreign intry)
-18	Director		129-18-8216 Usual Residence of Decedent	X	77	113.			10/30	/26	N.Y	.City,N.Y.
	land bw		10a. State 10b. County		10c. City, To	wn or Loc	ation	o :				10d. Inside City Limits
	Mary f sh	į	Md. Mon	tgomery			Sir	ver Sprin	ıg			1₽Yes 2□No
	28a	rec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	intry?
	3e ol	O O	2015 East We	st Hwy.				20910			U.S.	A.
	deatl ms 2	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or I	10-	14. Race - Amer Black, White	
9	after or Ite	F	1 ☐ Never Married 2 ☐ Mar				Yes 25 No		rio i nozii, oio.,		Specify: Bl	
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2121	within ne. than	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retir	nt Office	or	11.9	S. Gover	nment
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Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23e or 28e-f show eumatic event, the Modest Examinational be notified at	o Be	Egbert Livir					1	nie Best			
<u> </u>	shoul mark mark	2	19a. Informant's Name/Relations		19	b. Mailin	g Address (Stree	at and Number or F	Rural Route Nurr	ber, City o	or Town, State, Zi	p Code)
S	and 2 sealth ar n 27 is ner treu		Jeanne C. Douga		3	3001	Queens	Chapel Ro	4,009.b	it. R	ainier,M	d. 20712
ltimore,			20a. Method of Disposition	_	come	any cram	sition (Name of actory or other pl	acel	Date		ocation - City or T	
Ë	permit. Pages 1 Department of H Importent: If ite any injury or ot		1 ☐ Burial 2 ☐ €remation 1 ☐ Donation 5 ☐ Other (5		Chesa	apeal	ke Crema	tory, Inc	. 1/7/04	Be.	ltsville	, Md.
alti	mit.		21. Signature of Funeral Service	Licensee)	22.	Name and Add	ess of Facility		a .		
m	E E E E) any	W. S.	Nau	49	S. Was 25 Burro	shington oughs Ave	& Sons	Wash.	nc. D.C. 20	0019
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause	d the death. Do	not ente	or the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
等 Yi:	Physician		Immediate Cause (Final disease or condition	Eno	15/09	e /	Mevas!	Wir 1	-una	car	1cer	Onset and Death
	/Medical		resulting in death)	Due to (or as	s a consequenc			2(17)				
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	₽ ≅	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequenc	e of):						
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Ö,	e exection a		resulting in death, Last	Due to (or as	s a consequenc	e of);						
68760	ficate be executed physician and is the burial-transit	dicai		d			-					
-	= O 8	1 W 1	IF FEMALE:	23c. If yes, outcom-	a of programmy							
Вох	death certif e attending od for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal dea at time of death		Ectopic pregnan Other (specify)	су			23d. Date of delive Month	ory Day Year
o.	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death	3 🗆	Other (specify)					
۵.	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Physician/M	Part II. Other significant conditi	ons contributing to death	but not resulting	in the un	derlying cause g	iven in Part I.	23e. Dio	tobacco i	use contribute to	the cause of death?
ds	ures sign ld be								1 [Yes 2	□ No 3 12 P16	bably 4 Unknown
Records,	w requir been si should l	Completed							24a. Wt	s an	24b Were aut	oney findings available
Re	ne lav e has ge 2	E G							aut per	opsy formed?_	death?	opsy findings available ompletion of cause of
a	icien: Th certificate ector, pag	ပို	25. Was case referred to madica					OS Place of Dr	1 ☐ Yes eath <i>(Check only</i>		1 🗆 Yes	2 No
Vital		00	examiner?	Hospital:	ient 2 ER/0	Dutnation	3□ DOA 0	ther			6 ☐Other (Speci	(64)
o	ਦ ≑ ''	7: To	27. Manner eath	28a. Date of Inj	ury 28b	Time of	28c. Inj	ury at	28d. Describ			197
on	Attending Ph ir death. ector: After th by the funeral	to	1 a fatural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, D igation	ay rear)	Injury		ork?]Yes 2∐No				
Division of	or Attendate death Director:	iţi	3 ☐ Suicide 6 ☐ Could	ninger 200. Flace of fr	njury - At home, etc. (Specify)	farm, stre	et, factory, office	9		(Street ar		al Route Number,
	s after s after sl Direct sd in by	Certification:	4 Homicide	building, e	ic. (Specify)				City Gr 1	Own, Diale	*/	
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the			ng Physicien: To the bes Exeminer: On the basis								
	the Hin 24 the Figure 1	edical	one)	and manner s	tated.	and/or inv	estigation, in my	opinion, death oct	curred at the time	e, date and	piace, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certific			11 7	29c. Licer	nse number	592	29d. Da	te signed (Month,	Day, Year)
\cap	7,1			0/2	2.	IVL	١١١	シファー		01	1001	7
K	- (4)		30. Name and address of person			ı) (Type, f	Print) 860	57210	Ave. 2	vile	4048	
`			31 Data filed (Month Day Your	Javan MI			Silv	er sprig	J.MO	20	910	
	Sta	ate	31. Date filed (Month, Day, Year JAN 0 7 2	nna 2. Regis	trar's Signature.	1						

			For State Registrar	State of M	1arylan	d / Depa	artmen rtificate	t of H e of L	ealth a	and M		giene2 Reg. No.	004		332
	Dhusisi		1. Decedent's Name (First, Middle, Las								2. Date of De Month	Day	Year	3. Time of	Death
	Physici /Medic			larzo							Januar			2:10	р ^м
	Examin	er	4a. Fecility Name (If not institution, give		r)				Location				inty of Death		
			Crescent Cities 5. Social Security Number 6. S		ae (In vrs. I	ast birthday)		Kive 1 Year	rdale		8. Date of Bir	th	9 Birth	orge's	
	Funeral Director			□M 2∰F	93	Yrs.	Months	Days	Hours	Min.	Jan. 20	у, <i>Үөаг)</i> 0, 191(Cou	intry) hingto:	
	D		Usual Residence of Decedent												
	arylan show	_	10a. State 10b. County	_	10c. City	y, Town or Lo	ocation							10d. Inside Ci	
	Ba-f s	Sct	Maryland Prince	George's	1	Hyatts						10g. Citizen	of Minot Co.		
	with the or 2	吉	10e. Street and Number 6000 42nd Avenue	Apt 20	2		10f. Zip		20781				S.A.	andy :	
	72 hours after death with the Maryland Inatural; or Items 23a or 28a-f show disal Examinat must be inclifted at	Funeral Directo	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13. 1	Was Deced				ecify Yes or No Rican, etc.)		Race - Amer		
'	fler d	퍒	1 Never Married 2 Married	Armed Force: 1 ☐ Yes 2 2	? No						Rican, etc.)		Black, White	, etc.	
ဗ္ဗ	ral', o		3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 🗆 Yes	21 <u>31</u> No	Specify:			Spe	wity:	ite	.,
Maryland 21215-0036	72 hc	Completed by	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. Kind o	f Business/I	ndustry	
12	within ene. than	m	Elementary/Secondary (0-12)	College (1-4o	r 5+)		<i>DO NOT u</i> : nemak)			0	II a a		
22	e filed within al Hygiene. I other than vent, the Me		17. Father's Name (First, Middle, Last,	<u> </u>		пог	пешак	e1	18. Mothe	er's Nam	e (First, Middle		Home_		
an	d be ental	To Be	George E. Mont	gomery						Gra	ace Dav	V			
37	2 should be to and Mental Is marked or raumatic eve	-	19a. Informant's Name/Relationship (9		19b. Mailir	ng Address	(Street	and Numb	er or Rur	al Route Numb		wn, State, Z	ip Code)	
ž	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than *natural; or items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclified at		Lorraine Dwyer -	Daughter		6000	42nd	Aver	nue,		202, H	lyattsv	ille,	MD 20	781
ore,	of Health of Health fitem 27		20a. Method of Disposition 1 🔀 Burial 2 🖸 Cremation 3	Pamoval from Stat	20b. P	lace of Dispo emetery, crei	osition (Nam matory or o	ne of ther plac	e)		Date	20c. Location	on - City or T	Town, State	
Ē	Page ment mury o		'4 □ Donation 5 □ Other (Special		For						7/2004				and
Baltimore,	permit. Pages Department of temportant: If ite any injury or of		21. Signature of Funeral Service Lee	1000		22	2. Name an	d Addres	ss of Facili	^{ty} Gas	sch's Fu	uneral	Home,	P.A.	
	2 □ ≒ € Ø		South C	11/0//		4	/39 B	alti	more	Aver	iue, Hya	attsvil	lle. M	D = 2078	
			23a. Part1. Enter the disease, or com shock) or heart failure. List only Immediate Cause (Final	one cause a each	line.	n. Do not em	ter the mod	er or dylin	g, such as	carciac	or respiratory a	-		Approximate Interval Bette Onset and I	ween Death
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9	eath certific attending ph for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ncv.						224	Data of dali		
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	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	inderlying o	ause giv	en in Part	l.	23e. Did	tobacco use d	contribute to	the cause of d	leath?
rds	quires n sign uld be	ed by	Sovere AM	nis	DE	rue	ul	<u>_</u>			1 🗆	Yes 2□N	o 3∏Pro	bably 4 🖄	Jnknown
00	law requir as been si 2 should	Completed	Alhansale	Mie	vale	cel	lor	DUS	690	0	24a. Was	san 24	4b. Were au	topsy findings ompletion of c	available
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<u>ta</u>		Be C	25. Was case referred to medical examiner?					-55	26. Place	e of Dea	th (Check only	one)			
of Vital Records,	G 55	10	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpa	-	ER/Outpatie			4 (\$\vec{4}\)	ursing H	ome 5 Res			ify)	
Ē	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending		njury Da <i>y Year)</i>	28b. Time o Injury	1	28c. Injur Wor	yat k? Yes 2.⊡	No	28d. Describe	how injury oc	curred		
Sio		icati	2 Accident investigation 3 Suicide 6 Could not be	e og Dless of	lojuny - At h	ome farm et	M reet factor	-	195 2	1140	28f. Location	(Street and N	umber or Ru	ral Route Num	iber.
Division	2 # E C	Certification:	4 Homicide determined	building,	etc. (Specif	y) ,	1001, 140101	y, omos				wn, State)			
	Hospital 4 hours Funeral ety filled	edical Co	29a. Certifier 1 ★ Certifying Pl (Check only one) 2 ★ Medical Exa	nysicien: To the be miner: On the basis and manner	of examina	owledge, deat ation and/or in	th occurred ovestigation	at the tir	ne, date ar pinion, dea	nd place, ath occur	, and due to the rred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s	:)
	To the within 2 To the complet	Me	29b. Signature and title of centier	1	\ \ \	0	29	c. Licens	e number			29d. Date si	gned (Month	, Dey, Year)	
•	FSFO		1	JA J	- M	ツ	1) 4	82	13		Janua	ry 6,	2004	
_	(2)		30. Name and address of person who	completed cause of	f death (Item	n 23a) (Type, 4410	Print)	1th	Ave	2 10	uder	er 4111	LM 2	207	84.
	St	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ature	٠.								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 1:35 PM M 10, January Kenneth Russell Dame Physician 4c. County of Deeth /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Frederick Examiner Frederick College View Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Onlo 8. Date of Birth Sept. 29, 1910 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Hours Months Days **Funeral** M 2□F 93 Yrs. 288-10-9682 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County death with the Maryland 10a State 1 ☐ Yes 2 X No or than "natural", or items 23s or 28s-f show the Medical Exercices must be notified at Frederick Frederick Maryland 10g. Citizen of What Country? Direct 10f. Zip Code 10e. Street and Number U.S.A. 21702 8213 Edgewood Church Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2000 If Yes, Give Year or Dates: Black, White, etc. Specify: White Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or itee ury or other traumatic event, the Medical Estandual ury or other traumatic event, the Medical Estandual. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify Baltimore, Maryland 21215-0036 δ 3XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Tool Die and Maker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary M. Schmuck Forrest J. Dame 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6705 Ford Road, Frederick, Maryland 21702 Mrs. Neeta D. Falconer, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑-Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland Jan. 14, 2004 permit. Pages 1 Department of H Important: If ite any injury or ot once. Mount Olivet Cemetery 4 □Donation 5 □Other (Specify) ²² Name and Address of Eachity Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service Ucensee MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dyenmon.a Physician hornic Obstructive Pulmenty Disage Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Box 68760 Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death Year Month Day 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No 1□ Yes 2No certificate 26. Place of Death (Check only one) or Attanding Physician: 25. Was case referred to medical examiner? Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3□ DOA 2 ER/Outpatient 1 ☐ Yes 2 No Certification: To 28d. Describe how injury occurred this 28b. Time of 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death Injury 5 Pending 1 ☐ Yes 2 ☐ No Natural investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) death. 2 Accident Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 4 Homicide after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pelli within 24 hours To the Funeral 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 January 12, 2004 D 16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West Ninth Street, Frederick, MD 21701 Casper E. Cline III, M.D., 31. Date filed (Month, Say Wear) [2014 32. Registrar's Signature State Registra

Duckworth, Havold E.

					t in Black Inc ryland / Depa							•	010	01
			1 - For State Registrar		-	rtificate					Reg. No	4004	Ulj	34
	Physicia	an	1. Decedent's Name (First, Middle, Las		Dualana					2. Date of Do	eath Da	y Year	3. Time of D	
	/Medic Examin	al	Harold Ed 4a. Facility Name (If not institution, give Lions Manor Nursin		Duckwort			Location o	of Death	Janus	4c.	う。 County of Dea legany		TM
	Funeral Director		5. Social Security Number 217-10-5202	x 7. Age	(In yrs. last birthday) 7 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bi Month, D. Dec 2	rth	0.8	rthplace (State or i	Foreign
	Maryland -1 show	tor	Usual Residence of Decedent 10a. State MD 10b. County Allegany	,	10c. City, Town or Lo Cumb		t		·				10d. Inside City ★□ Yes 2	
	with the 3a or 28a It be noti	Funeral Director	10e, Street and Number 11716 Daisy Avenu	е		10f, Zip		1502			10g. Cit	tizen of What C	Country?	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	δ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? Mary Yes 2 No. If Yes, Give Year or Dates:	. 1	Was Deced f Yes, spec	rify Cubar Y	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh	ite, etc.	
D-C 7 7	əd within 72 hc rgiənə. ıar than "natuı t, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or 5+	lite. I	kind of wor DO NOT us	k done d	furing most			Text		s/Industry	
yland	ould be file Mental Hy arkad oth atic event	To Be	17. Father's Name (First, Middle, Last) Edward Duckwor					Jane	et D	(First, Middle UCKWOI	rth			
, Mar	and 2 sh ealth and m 27 is m her traum		19a. Informant's Name/Relationship (T Harold Duckworth	/рө, Print) SON				ster R						02
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מ	permit Depar Impor any in		21. Signature of Funeral Service Licens	7 Acu	pu		Virgir	nia Ave	enue:	Cumber		MD 2150		
	nysician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate days (Final disease or condition resulting in death)	ne cause on each liñe a.	the death. Do not entered at the consequence of):	0		a, such as ເ <u></u> ລົທ ທ່າ		r respiratory a	arrest,		Approximate Interval Betwee Onset and De	ath
	te be executed ysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Lind Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):									
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משבו וג	To the Hospital or Attanding Physician: The law requir within 24 hours alter death. To the Fungeal Director. After this certificate has been si completely filled in by the funeral director, page 2 should	Completed								24a. Was auto perfo 1 🗆 Yes	an psy prmed? 2) No	prior to death?	utopsy findings ava completion of causes 2 No	ailable se of
712	sician certifi irector	o Be	25. Was case referred to medical examiner?	Hospital:	A 0 5 5 7 (0 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		Othe	2. 4		(Check only o	-	. 700	V 1898000	
5	ding Phy: h. After this funeral di	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time of		Bc. Injury Work		2	ne 5 ∐ Hesi 8d. Describe		6 □Other (Spery occurred	ecify)	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)	eet, factory,	, office		2	8f. Location (City or To	Street an wn, State	d Number or R)	ural Route Numbe	ər,
	he Hospit in 24 hours he Funera pletely fille	edical	29a. Certifier 1 Certifying Phy 2 Medical Example 10 Medical Example 1	sician: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or inved.	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s) date and	and manner a d place, and du	s stated. e to the cause(s)	
	Tot withi Tot com	Σ	29b. Signature and the of certifier	M		29c.	License	number 3	371		29d. Dat Jan	te signed (Mon	th, Day, Year)	4
			30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type, I	Print)	LÚGÍ:	0	391.	1982	¥. /	lik =		-
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	TU T	IVCi	w	TUCK	atun	u,	IL O	11200	

Registrar DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of I tificate of	Health and Death		Reg. No.	04 01335
	Physici		1. Decedent's Name (First, Middle, Last) John Edward Donal	ldson				2. Date of De Januar		3. Time of Death 2:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give s 6020 Hillside Road			4b. City, Town, o St. Lec	or Location of De Onard	ath	4c. County of	of Death ert County
45	Funeral Director		311-20-2230	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days			y, Year)	9. Birthplece (State or Foreign Country) Washington, DC
	the Maryland 28a-f show cuffed at	Director	Usual Residence of Decedent 10a. State 10b. County MD Calvert Co 10e. Street and Number		y, Town or Lo				10g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with with	Ö	6020 Hillside Road			20685			U.S.	·
960	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show valcal Establish must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	'		Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race	e - American Indian, k, White, etc.
Maryland 21215-0036	within 72 h ene. thsn "natu he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. I	lent's Usual Occu kind of work done DO NOT use retire	during most of w	vorking	16b. Kind of Bu	
22			12 17. Father's Name (First, Middle, Last)		Supe	rvisor	18 Mother's N	ame (First, Middle		Government
yland	d tal	To Be	Walter Donaldson				Kate I	oveless		
, Mar	nd 2 sulth ar 27 is r trau		19a. Informant's Name/Relationship (Type Anita L. Donaldson	(Wife)	6020	Hillside	Road, S	Rural Route Numb St. Leona		State, Zip Code) Land 20685
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		sition (Name of natory or other pla Veterans		nuary 9, 2004		City or Town, State ham, Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of F	Le le						alvert, P.A. gs, MD 20736
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deathe cause on each line. M(Ltultuh)	c Nonsa				rest,	Approximate Interval Between Onset and Death UM MinHo
),	-14	Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
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P.O. Box	at the death certificate be executed by the attending physician and lached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery hh Day Year
	w requires that been signed t should be deta	by	Part II. Other significant conditions con	stributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.		_	bute to the cause of death? 3 Probably 4 Unknown
al Records,	The lay ate has page 2	Completed						24a. Was auto perio 1 Yes	rmed? de	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oti		eath (Check only o		
o	fter fter	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	T. C. C. C. C.	Home 5 Resident	dence 6 ∐Othe now injury occurre	
Division	i Diste	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (City or Tox		or or Rural Route Number,
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	To the within 2 To the complex	Me	29b. Signature and title of certifier			29c. Licen:			29d. Date signed	(Month, Day, Year)
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1	0+1		30. Name and address of person who con Kenneth L. Assett	110 Hospital	23a) (Type,	Print)	Prince F	redense t	NO ZOL	18
1	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 5	32 Registras Signa	iture	bute)			

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	Disconint		1. Decedent's Name (First, Middle	a, Last)					2. Date of De.	ath Day	Year	3. Time of	Death
	Physici /Medic		Mar	y L. Ensl	OW				January		2004	1750	РM
	Examin		4a. Facility Name (If not institution), give street and nu	mber)		4b. City, Town, or	Location of Dea	th	4c. Coun	ty of Death		
			Laurelwood Ca				Elkton			Cec			
ш	Funeral		5. Social Security Number	6.Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	. (Month, Da	v. Year)	Cour		
	Director		178-14-1892 Usual Residence of Decedent		85	115.			AUG 7,	1918	Pen	nsylva	ania
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside Ci	ity Limits
	Many fish	tor	Maryland Cec	;1	F	lkton						1 X Yes	2 🗌 No
	1 the	Director	10e. Street and Number			TVCOIL	10f. Zip Code			10g. Citizen of	What Coun	try?	
	13e o	JE D	100 Laurel Dr	ive			21921			Unite	d Sta	tos	
	deat	Funeral	11. Marital Status		edent Ever in U.		Was Decedent of Hi	spanic Origin? (Specify Yes or No-	14. Ra	ce - Americ	an Indian,	
ဖွ	after or ite	F	1 ☐ Never Married 2 ☐ Marr		2 🛛 No	ì	f Yes, specify Cuba 1 □ Yes 2☑ No	Specify:	no nican, etc.)		ack, White,	etc.	
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22	Hygie ther nt,	ပိ	12 17. Father's Name (First, Middle,	l ast)		ПО	memaker	18 Mother's Na	me (First, Middle,		r Own	Home	
Maryland 21215-0036	d be ental	o Be	Isaac Andakia	,					za Magzar		nio)		
<u></u>	Shoul nd Me mark imeti	2	19a. Informant's Name/Relations			19b. Mailin	g Address (Street a				State Zio	Code)	
Š	nd 2 lith a 27 is r treu		John C. Enslo	w, Jr./So	n		North Wil						
ē,	s 1 ar		20a. Method of Disposition	·	20b. P	lace of Dispo	sition (Name of		Date	20c. Location			
Ë	Page ient c int: if iry or		1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other (S)		State R.	A. Fer	natory or other place Tris & Co	• 114,	uary 2004	West C	hestei	C ,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If lien 27 is marked other then "natural," or items 23e or 28e-1 show any injury or other treumetic event, it is Medical Examinational by multiple at once.		21. Signature of Funeral Service	Licensee	- 1 111	22	Name and Addres	s of Facility		Pennsy	LVCIII	1	
m	e G in a G		Donald	8. 1	رددلار	110	icks Home 03 W. Sto	ckton S	neraıs, E treet, El	lkton.	Maryla	and 21	921
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	/Medical Examiner		resulting in death)	Due to	(or s consequ	uence of):	-	11 0					
	Lammer		Sequentially list conditions,	b									
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	and and Il-tran	хап	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):	_				-		
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X	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant		come of pregna					23d. Da	ate of delive	v	
. Box	that the death certific ed by the attending p detached for use as	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregn	oirth 2∏Fetal nant at time of de		Ectopic pregnancy Other (specify)					-	/ear
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	e Hospitel or Atten 24 hours after deati e Funerel Director: etely filled in by the		29a. Certifier J Certifyid	g Physician: To the	best of my know	wledge, death	occurred at the time	e, date and place	e, and due to the c	ause(s) and m	anner as sta	ited.	
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01,	/16/04		For State Registrar			State o	Maryl		epartm Certific				lental H	ygiene Reg. No	40	04	0	338
	Physicia	an	Decedent's Name	e (First, Middle	e, Last)								2. Date of D Month	eath Da	ay	Year	3. Time o	f Death
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	Examin	er	4a. Facility Name (/	f not institution	n, give stre	et and nu	mber)		4b. (ity, Town,	or Location	n of Death		40	. County	of Death		
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	Funeral		5. Social Security N	1		1 2 🗆 F		yrs. last birtl	Mon	ths Days	Hours	er 24 Hrs. Min.	8. Date of B (Month, D			Cou		
	Director		577-24-7		- 22		81		rs.				Mar 19	9, 19	922_	Penr	ısylva	nia
	land		10a. State	10b. County			10c.	City, Town	or Location								10d. Inside C	ity Limits
	Mary	ō	MD		Cals	vert				Ch	ocano	eake E	Roach				1 🗌 Yes	2 No
	28a	Director	10e. Street and Nu	mber	cary	VELC			10f	Zip Code	csape	ane i	Cacii	10g. Ci	tizen of V	/hat Cou	ntry?	
	3a or		5502 Col	lonial	Drive	ے				20	732				USA			
	death ms 2	Funeral	11. Marital Status			. Was Dec	edent Ever i	n U.S.	13. Was D	ecedent of I	Hispanic O	Origin? (Spe	cify Yes or N	lo-	14. Race		can Indian,	
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93	ours	d by	3 Widowed	4 Divorced		Year or D	ates: 194	2-45	1016	s 21 No	- Specii,	y. 			Specify	who	te	
5-0	72 h "natu	ete	(Spec	15. Deceden	t's Educat st grade c	tion completed)			Decedent's (Give kind o	work done	durina mo	ost of worki	ng	16b. K	Kind of Bu	siness/In	dustry	
121	within 72 hours after death with the Maryland ene. then "naturel; or Itams 23a or 28a-f show the Medical Ever her rest ke notified at	Completed	Elementary/Seco	ndary (0-12)		College (1-4or 5+)		life. DO NO		,			TT 0	. D-		G	
7	filed v Hygie other t	ပိ	17. Father's Name	(First Middle	l ast)			1 TE	tter	Carrie		her's Name	(First, Middl				Servi	.ce
Maryland 21215-0036	2 d 2 d	Be			_	Del	_									_		
Ž	should but Ment markac	မှ	Luther 19a. Informant's Na	Kriebe ame/Belations		Ecker Print)	τ	19h	Mailing Add	ress (Street	Edi		Rile I Route Num		nnar		Codel oc	
Z	d 2 sho th and th sm 17 Is mu traum																	
	1 and 2 Health tem 27 other tra		Betty A. 20a. Method of Dis		L, W.	rre	20	b. Place of	Disposition (Name of			Box				eacn, own, State	
õ	Pages nent of int: If it		1 🎇 Burial 2 1 4 □ Donation			noval from			, crematory	•	,	01/00	/2004	C1	1		100	
altimore,	그 돈은 글		21. Signature of Fu				l Iv.	ı) vet		CEITIE I and Addre	The second second	econocide in carbonization of	/2004	cne	ltenl	nam,		
B	permi Depar Impo any ir	(1)	V Wal	De m	RA	~~	-		Raus	ch Fu	neral	Home	, P.A.	. 0	wing	c M	D 207	136
			23a. Part1. Enter t	he disease, or	complica	tions that o	caused the d	leath. Do no	•					_	W1119		Approxi <i>m</i> a	te
C B	Physician		Immediate Cause	rt failure. List (Final	only one	cause on e		norm	p.1 &	m in a	~						Interval Be Onset and	Death
	/Medical		disease or condition resulting in death)	ж	a	Due to	(or as a con			100111	<u> </u>					-		
	Examiner		Conventially list as	aditions	, h													
	D #	ner	Sequentially list co	mediate) "-	Due to	(or as a con	sequence o	i)e									
	executed in and ial-transit	xamln	Cause (Disease or that initiated events resulting in death) I	injury S	С.													
90,		ш	resulting in country	Last		Due to	(or as a con:	sequence o	1):									
Division of Vital Records, P.O. Box 68760	ires that the death certificate be ex signed by the attending physician d be detached for use as the buria	by Physiclan/Medical			d													
9 ×	ding I	/Me	IF FEMALE:		230	If yes our	tcome of pre	onancy										
Bo	atten for u	lan	23b. Was deceden in the past 12	months?	250	1 Live t	oirth 2 F	etal death	3 ☐Ectop	c pregnanc	у				23d. Date Mon		•	Year
Ö	the de	ysic	1 ☐ Yes 2 [9 ☐ Unknown			9□ Unkn		Or GOLD!	3 CJ O(114)	(Specify) _								
٥.	that the ed by deta	/Ph	Part II. Dther signif	ficant condition	ons contril	buting to d	eath but not	resulting in	the underlyi	ng cause giv	ven in Part	t I.	23e. Did	tobacco	use contri	bute to the	ne cause of o	death?
g	uires sign ld be	d b		1	DINB	ETE	25						10	Yes 2	ØNo.	3 ☐ Prot	ably 4 🔲	Unknown
õ	w require been si should I	Completed				KIN.		02	(00	201			24a. Wa	s an	24h W	/ere auto	nsv findings	available
Re	he la e has ige 2	mc				74.0							auto	opsy tormed?	d	eath?	psy findings mpletion of a	ause of
a	in: T		25. Was case refer	red to medical							OC Dias	an of Dooth	1 ☐ Yes (Check only	2 Z No	1	Yes	2 No	
Š	s cert	To Be	examiner?		-	pital:	Inpatient 2	2 ☐ ER/Out	patient 3	DOA Ott			ne 5□Res		6 □Othe	r (Snecif	w)	
o o	g Phy er thii	n: T	27. Manyer of Deat	h		28a Date		28b. Ti	me of	28c. Injui Wo			8d. Describe				<i>''</i>	
Ö	ttending death. ctor: Aft / the fun	atio	 Natural Accident 	5 🗌 Pendin investi	gation	(MOI)	ui, Day 16a	"	ury M		Yes 2□	□No						
<u>vis</u>	er des	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could a		28e. Place	of Injury - A	At home, fan	n, street, fac	ctory, office		2	28f. Location	(Street ar	nd Numbe	r or Rura	l Route Num	iber,
Ö	rs afte	Cert		1		5010	g, 0.0. (Op					1	2, 0 10	, 01216	-,			
	t hour uner	cal	29a. Certifier (Check only	t⊠ Cartifyin 2 Medical	g Physici Examiner	ian. To the	best of my	knuwiedge, nination and	death coou	red at the ti	me, date a	and place, a	ind due to the	date and) and mai	ner as s	ated.	(3
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Medical Certification:	one)			and man	ner stated.		Jvostiga									,
	To Con	2	29b. Signature and	title of certifie	1	0	a h	2		29c. Licens			7	29d. Da	te signed	(Month,	Day, Year)	
				1	X		///	1)		V.	01	4		1/	5/0	24		
,	7 TI	12	30. Name and addr	ess of person	who comp	NO K	se of death (Item 23a) (T	ype, Print)	Ω.		635 redera	وأء	mx				
	0 +1		31. Date filed (Mon	th. Day Yash	e 1	32 5	Registrat s Si	ignature	1	[KII	ICEFR	ever	UZ 1	1112				
	Sta Registr		Date mee (Mon	JAN	06	20031	Man	12 1 A	K de	all I								

			1 - For State Registrar	State o	of Marylan	id / Depa	artment of rtificate of	Health a	and M		giene Reg. No.	2004	Control	339
	Physici	an	1. Decedent's Name (First, Middle, Last,							2. Date of Dea	, Day	2004	3. Time o	
	. /Medic	cal	Ethel Frank		mbarl	-	4b. City, Town,	ar Lagation o	of Doosh	1	4	2004 County of Deat	21:45) P M
	Examin	ner	4a. Facility Name (If not institution, give Holy Cross Hospit		mber)		Silver					ntgome1		
	Funeral		Social Security Number 6. Security Number	(7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	_	8. Date of Birt			hplace (State	or Foreign
	Director		416-54-6690	M 200 F	63	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da 11 9	1940	Alab	untry) ama	
	DU N		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside (City Limits
	Maryik faho	5	MD Prince Ge	orge's			hington							s 2 No
	r 28a-	Director	10e. Street and Number			10 1100	10f. Zip Code				10g. Citi	zen of What Co	untry?	
	15 with	al D	2004 Frontier Cou	rt			207	44			U	.S.A.		
	r dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of f Yes, specify Cut	Hispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	-	14. Race - Ame Black, White		
20	s afte	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or D	ve	1	1⊡Yes 2⊠ No						Black	
3-003e	sturel		15. Decedent's Edu		vales.	16a. Deced	dent's Usual Occu	pation			16b. Ki	nd of Business/	Industry	
2	Media 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	1-4or 5+)	(Give	kind of work done DO NOT use retire	during mos d)	t of workir	ng			Í	
7	ygiene /giene lar the	Con		College (3+"	Posta	l Worker	,				rernment		
	be fill ntal H ad oth	Be	17. Father's Name (First, Middle, Last) Bill Ford							(First, Middle, anklin	Maiden	Sumame)		
2	hould d Mer marks matic	ဥ	19a. Informant's Name/Relationship (Ty	ne Print)		19h Mailir	ng Address (Stree	t and Numbe	ar or Rum	Route Numbe	r City o	r Town State 7	in Code)	
<u>8</u>	nd 2 sulth an 27 is rtrau		Willie P. Chambli		sin		Spring				-)349
ອັ	ss 1 a of Hea itam othe		20a. Method of Disposition		20b. F		sition (Name of natory or other pla			ate		cation - City or		
Ĕ	Page ment a ant: If ury or		1 △ Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)	lemoval from	State		Cemetery		1-10-	-04	Mont	gomery,	Alabam	ıa.
Бащто	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menall Hygiene. Department of Heath and Menall Hygiene. Important: If tiern 27 is marked other then "naturel", or liems 23e or 28e-f show any injury or other traumatic avant, I'm Medical Examinar must be notified at QDee.		21. Signature of Funeral Service Licens	99	211		. Name and Addr							
-	0 D ≥ 8 O		23a. Part1. Enter the disease, or compl	ral	Consideration of the state of t		474 Land					Marylan	d 2078.	
			shock, or heart failure. List only of	ne cause on	each line.			ing, such as	cardiac oi	respiratory at	1651,	- }	Interval Be Onset and	tween
	nysician /Medical		disease or condition resulting in death)	a	Sept (or as a conseq	icemia								
	Examiner					reatit	is							
-	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undervin. Cause (Disease or Injury	Due to	(or as a conseq	uence of):								-
	and and I-trans	Examine	that initiated events resulting in death) Last	Due to	Addi	sons D	isease							
3/00,	cate be executed physician and the burial-transit	dlcal E		4	(0. 40 4 00004	201100 017.								
20	uficate g phys as the			J										
ŏ	w requires that the death certific been signed by the attending p should be detached for use as t	iclan/Me	230. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	:v			2	3d. Date of deli	,	V -
	e death the atter ned for u	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of d		Other (specify) _	,				Month	Day	Year
Ţ.	requires that the een signed by th hould be detache	Physi	Part II. Other significant conditions con	atributing to d	eath but not res	ulting in the ur	nderivina cause a	ven in Part I.		23e. Did to	obacco u	se contribute to	the cause of	death?
S. C	urres signe Id be	d by	,				,, 5.					□No 3□Pro		
Cord	s beer s beer shou	ompleted						•		24a. Was	an	24b. Were au	topsy findings	available
ב	The law ste has b cage 2 sl	mo								autop perfor	rmed?	prior to death?	ompletion of a 2⊠ No	cause of
	itan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o		1 1 103	200 140	
5	Phyaician: rthis certific ral director,	은	1 ☐ Yes 2 🗷 No			ER/Outpatien	1 3 LI DOA					Cother (Spec	ify)	
5	ii or Atlanding Phyalcian: The lavalete de aleter dearer. Ther this certificate has I piractor: After this certificate has d in by the funeral director, page 2.	ertification;	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Wo	ıryat ork?]Yes 2.∐!		8d. Describe h	iow injury	occurred		
	or Attanding ther death. Diractor: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Homiside determined	28e. Place	of Injury - At he	ome, farm, str	eet, factory, office			8f. Location (S	Street and	d Number or Ru	ral Route Nur	nber,
5	al or safter safter or din b	Certi	4 - Homicide determined	build	ing, etc. <i>(Specit</i>	y)	,			City or Tow	m, State)			
	To the Hospital or Attan within 24 hours after death To the Funeral Diractor: completely filled in by the	edical (29a. Certifier 1⊠ Certifying Phy (Check only one) 2 ☐ Medical Exami	ner: On the b	a best of my kno asis of examina ner stated.	wledge, death tion and/or inv	n occurred at the trestigation, in my	ime, date an opinion, deal	d place, a th occurre	nd due to the d d at the time, d	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier				29c. Licen	se number		:	29d. Date	signed (Month	, Day, Year)	
	7		lule	CONNI	E LE,	MD	D6	0619			1/6	12004		
	(5)		30. Name and address of person who co	mpleted cau	se of death (Iten	n 23a) (Туре,						20010		
	Sta	ate.	Connie Le M.D. 31. Date filed (Month, Day, Year)		Forest Registrar's Signa		oad Silv	er Spr	ing .	Marylar	nd 2	20910		
	Registr		JAN 0 8 2004		ie de									

			1- State of M	aryland / Depa <i>Cer</i>	artment of H			iene 2001	01340
			Decedent's Name (First, Middle, Last)				2. Date of Deatl	1	3. Time of Death
	Physicia		Lois Randall Fortwengler				Month January	3, 2004	10:30 a ^M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number,)	4b. City, Town, or	Location of Death		4c. County of Dea	
		١.	2808 Cheverly Avenue		Cheverl			Prince G	
	Funeral Director		5, Social Security Number 198–20–5881 6. Sex 1 □ M 2	ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 13	Year) Co	thplece (State or Foreign ountry) nsylvania
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla Pohor	ō	Maryland Prince George's		oution				1 ∑Yes 2 □ No
	28a-1	Director	10e. Street and Number	Cheverly	10f. Zip Code		10	Og. Citizen of What Co	ountry?
	Se or		2808 Cheverly Avenue		20785			U.S.A.	
	death	Funeral	11 Marital Status 12. Was Deceden	Ever in U.S. 13.	Was Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23e or 28e-f ehow enty injury or other traumatte event, I'm Medical Exaciliar must be routlind at anone.	by Fur	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ 3 ☒ Widowed 4 □ Divorced Year or Dates:	No	ryes, spectry Cubar I□Yes 2XINo	Specify:	Hican, etc.)	Specify: Wh	e, etc. nite
ğ	2 hou		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation	200	16b. Kind of Business	/Industry
215	e.	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	kind of work done d OO NOT use retired,		rig		
2	ed wi	Son	12	Infor	nation Cl			A.P.C.I.	***
Maryland 21215-0036	be filted Hydrau of oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
$\frac{8}{2}$	ould J Men narke	2	Benjamin E. Randall	tob Marilla	- Add (Carada	Mary Dor		ight City or Town, State, .	7in Codel
Ma	d 2 sk th and 7 is n traun		19a. Informant's Name/Relationship (Type, Print) Michael J. Fortwengler - S					e, Maryla	
ė,	1 and Heali em 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of			20c. Location - City or	
JO L	ages ont of it: If it		1 Burial 2 □ Cremation 3 □ Removal from State Graph of the Company of the Com)	natory`or other place		2004	haltanham	, Maryland
altimore,	nit. Partme ortan injur		21. Signature of Funeral Service Licensee /	/ N 22	. Name and Addres	is of Facility Ga	sch's Fu	nertennam neral Hom	e. P.A.
ä	Den Per		Illah M. Me						ryland 20781
	11.00		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not enti	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final	atic Breat	Cancer				Onset and Death 12 Years
	/Medical Examiner		resulting in death)	s a consequence of):					12 10015
4	Examiner	_	Sequentially list conditions, b.						
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	в в сопвециалов of):					
•	xecut and al-trar	Examiner	that initiated events c.	s a consequence of):					
8760,	icate be executed physicien and s the burial-transit	dical E	d						
9	ifficating by as the	ledic							
ŏ	feath certific attending pl	N/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom		Ectopic pregnancy			23d. Date of de	
O. B	e dea he att	Physician/Me	in the past 12 months? 1 □ Yes 2 ☒ No 4 □ Pregnant :		Other (specify)			Month	Day Year
<u>م</u> ن	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death	but not reculting in the cu	adorhina cauca auc	on in Part I	23a Did tob	acco use contribute to	the cause of death?
Division of Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ed by	Fatth, Other significant continues continues to continue to				1 🗆 Ye		robably 4 Unknown
000	e law re has beo	Completed					24a. Was ar autopsy		utopsy findings available completion of cause of
m m		Com					perform	ned? death?	2 □ No
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?		10.	26. Place of Death	(Check only one	9)	
of	Physician: this certific ral director,	P	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpat			4 🗆 I vul sing Ho		nce 6 Other (Spe	cify)
u C	Jing F	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	ay Year) 28b. Time of Injury	Work	Yes 2 □ No	28d. Describe ho	w injury occurred	
isi	Attending it death. ector: After by the funer	ficat	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, larm, str			28f. Location (Str	eet and Number or R	ural Route Number,
Š	after Direct	Certification:	4 Homicide determined building, 6	itc. (Specify)	,		City or Town	, State)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1X Certifying Physicien: To the besis and manner and manner and manner services.	of examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, spinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	s stated. e to the cause(s)
ı	To the comple	Mec	29b. Signature and title of sertifier	nerou.	29c. License	number	29	d. Date signed (Mont	h, Day, Year)
,	(12)		pour Xtan	men whi	D5382	29	J	anuary 5,	2004
	(1)		30. Name and address of person who combleted cause of					0 1 1	1m 00==0
	Sta	to	31. Date filed (Month, Day, Year) 32. Regis	5 Greenway	center Dr	rive, Sui	ce 205,	Greenbelt,	MD 20/70
	Registr			1 Coul					

			1 - For State Registrar	State of Ma	aryland / Dep	artmer	nt of H	ealth and Death	Mental Hy	rgiene 200	4 01341
	And the	P	Decedent's Name (First, Middle, Last)						2. Date of D	eath	3. Time of Death
E	Physici		James McKnight Fre	y.					Januar	y 2, 2004 Year	1:00A ^M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City	Town, or	Location of De		4c. County of Dea	
1	CXAIIIII	iei	Casey House	ŕ		Rock	vill	e		Montgomer	·v
isk'	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda) If Unde	r 1 Year	If Under 24 H			rthplace (State or Foreign country)
9.72	Director			/ 2□ F	71 Yrs.	Months	Days	Hours Mi	Dec. 7	ay, Year) T11	inois
3	2011 × 20		Usual Residence of Decedent			1				, 1700 1111	111010
	ylan		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Mar.	io	Maryland Montgomer	y	Potomac						1 ☐ Yes 2¥☐ No
	h the	<u>ē</u>	10e. Street and Number			10f. Zi	p Code			10g. Citizen of What C	Country?
	23a c	Funeral Director	8106 Inverness Ridge	e Road		208	354			USA	
	dea	ner	11. Marital Status	. Was Decedent I	Ever in U.S. 13	. Was Dece	dent of Hi	spanic Origin?	(Specify Yes or N erto Rican, etc.)	o- 14. Race - Am Black, Wh	
9	after or Ite	교	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 🛣 N	ło	1 ☐ Yes		Specify:	710 1 110411, 010.7	The second	110, 010.
8	ours	1 by	3 Widowed 4 Divorced	Year or Dates:			- 41			Specify: Wh	ite
215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-1 show the Madical Examiner must be natified at	Completed	15. Decedent's Educa (Specify only highest grade	tion com <i>pleted)</i>	(Giv	edent's Usu	ork done o	luring most of w	orking	16b. Kind of Busines	s/Industry
7	ithin ne.	ğ	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT					
7	ygier ygier yer ti			5+	Asst	Dir.	for			Federal Go	vernment
pu	be fill H d ott	Be	17. Father's Name (First, Middle, Last)							a, Maiden Surname)	
Х	ould Men Mrke Mrke	ဥ	Raymond Frey						ia McKni		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Madicial Examiner must be notified at		19a. Informant's Name/Relationship (Type	a, Print)	19b. Ma	iling Addres	s (Street a	ind Number or i	Rural Route Numi	per, City or Town, State,	Zīp Code)
	s 1 and 2 M Health Item 27 other tra		Nancy E. Frey/ wife		8106	Inve	rnes	s Ridge	Rd. Pot	omac, MD 20	854
O.	of H of H If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rei	moval from State	20b. Place of Dis cemetery, cr	osition (Na ematory or	me of other plac		nuary	20c. Location - City o	r Town, State
Ë	Pages ment of I ant: If Ite ury or o		* 4 □ Donation 5 □ Other (Specify)		Bayview				2004	Baltimore,	
Baltimore,	permit. Pages Department of Important: If It eny injury or once.		21. Signature of Funeral Privice Licenset	011	0	22. Name a	nd Addres	s of Facility Cremat	ion Serv	ice P.O. B	ox 784
<u>—</u>	2011	1	Devery I He	XHO 1							le, MD 21029
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Advanced Due to (or as	Hodgkin a consequence of):						Approximate Interval Between Onset and Death 6 months
68760,	cate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as	a consequence of):						
P.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic p				23d. Date of de Month	elivery Day Year
Records, F	w requires the been signed should be de	eted by F	Part II. Other significant conditions continued in Secondary Malignant		-	underlying	cause give	en in Part I.	. 1	21	Probably 4 Unknown
al Rec	Physician: The law this certificate has ral director, page 2.8								1 ☐ Yes	opsy prior to ormed? death? 2√√ No 1 ☐ Ye	
Vital	sicial certii recto	Be	25. Was case referred to medical examiner?	spital:			Othe Othe		eath (Check only		
of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ation: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ∐ Inpatie 28a. Date of Injud (Month, Da)	nt 2 ER/Outpati ry 28b. Time (Year) Injury		28c. Injury Work	4 🗆 Nursing		idence 6 X Other (Sp.	ocify) hospice
Division	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer.	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc					City or To	(Street and Number or F wn, State)	
	the Hosp in 24 hou the Funel pletely fil	ledical	(Check only	cian: To the best of er: On the basis of and manner sta	examination and/or	investigation	n, in my op	inion, death oc	ce, and due to the curred at the time	cause(s) and manner a date and place, and du	e to the cause(s)
	with To I	Σ	29b. Signature and title of certifier				c. License	_	- 10-	29d. Date signed (Mon	th, Day, Year)
			Hallie	ce_			DP	P41	218	01/02/	04
()	0) 000		30. Name and address of person who com	pleted cause of d	eath (Item 23a) (Typ						1
(S			Charles Harrison M.	D. 6001	Muncaste	r Mil	1 Rd	Rockvi	11e, MD	20855	
	Sta Regista		31. Date filed (Month, Day, Year) JAN 0 6 200	32. Registra	ar's Signature	back	,			-	

		1_ For	State of Maryland / [Department of Health a Certificate of Death	and Mental Hygie	ne 2004 0134
Dhyais	ion	Registrar 1. Decedent's Name (First, Middle, Las				3. Time of Death
Physic /Med Exami	ical	VARLAN 4a. Facility Name (If not institution, give	GUADELOU street and number)	4b. City, Town, or Location o	JANUAK'	4c. County of Death
			NWCOD DRIVE		LLE MD	Montgomery
Funera Director		280-10-4022 ,	du off	thday) If Under 1 Year If Under 2 Months Days Hours Yrs.	Min. 8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country) Trinadad
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery Bur	n or Location tonsville		10d. Inside City Limits 12 Yes 2 □ No
with the 3a or 28a	i Director	10e. Street and Number 14902 Falconwood	Or.	10f. Zip Code 20866		Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examinating must be rigitlised at hone.	by Funerai	11. Marital Status 1 Never Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin from the Specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
in all years of 2.12.13.00000000000000000000000000000000	Completed	15. Decedent's Ed (Specify only highest gra	de completea)	Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	. Kind of Business/Industry
d with giene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Entrepreneur		Private
al Hyg	Be	17. Father's Name (First, Middle, Last)			r's Name (First, Middle, Maid	den Sumame)
Menta Menta arked	10	John Guadeloupe			llie Raymond	
nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (7) Doreen Guadelou		o. Mailing Address (Street and Number 4902 Falconwood Di	r. Burtonsvil	le, Md. 20866
of Hear		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 反	20b. Place of cemete	of Disposition (Name of ary, crematory or other place)	Date 200	Location - City or Town, State Island
Page ment ent: If ury o		'4 □Donation 5 □Other (Specify	Wester			. Thomas, Virgin
permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		21. Signature of Funeral Service Licen	See	22. Name and Address of Facility der S. P. 5538 Mariboro	y Tke/Funeral H	mes, Md. 20747
Physiciar /Medica		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		IC CANCER	cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
te be executed by ysician and ine burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence C. Due to (or as a consequence d.			
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and radicionary page 2 should be detached for use as the burial-transit rat director, page 2	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
law requires that as been signed by 2 should be deta	5	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Munknown
l or Attending Physician: The law requires I after death. Director: After this certificate has been signs in by the funeral director, page 2 should be	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 🛣	
ian: ortifica ctor. p	Be	25. Was case referred to medical examiner?			of Death (Check only one)	
hysic his ce I dire	10	1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O		rsing Home 5X Residence	
Attending Part death.		27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of 28c. Injury at Work? M 1 Yes 2	28d. Describe how	njury occurred
al or Atte	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, late)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director.	edicai ((Check only 2 Medicel Exar	niner: On the basis of examination a	ge, death occurred at the time, date an nd/or investigation, in my opinion, dea	th occurred at the time, date	and place, and due to the cause(s)
To the H within 24 To the F	Me	29b. Signature and title of certifier	MD PhD Medical	Fellow 29c. License number	5889 <i>5</i>	Date signed (Month, Day, Year) 1-6-04 21231 adway, Baltimore, MD
(6)		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) Tokus Healing Hesp	ital 401 N R.	21231 adway Baltimore MD
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	had s	1 10 10	/ /

			1 - State Registrar	ite of Maryland		artment <i>tificate</i>			nd M		iene,	004	01343
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Joseph W. Graves,							2. Date of Deat Month January	Day 4,	Year 2004	3. Time of Death 11:55 p M
	Examir	ner	4a. Facility Name (If not institution, give street 3114 Lancer Place 5. Social Security Number 6. Sex	and number) 7. Age (In yrs. las	et highday)	4b. City, To		Location of Hyati If Under 2	tsvi	11e 8. Date of Birth			eorge's
	Funeral Director		214-03-8317 Usual Residence of Decedent	OF 88	Yrs.		Days	Hours	Min.	(Month, Day, Dec. 15,	Year) 191	5 Was	hplace (State or Foreign unity) Shington, DC
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itams 23s or 28s-f show event, the Madical Exercities that the truffied at	Director	10a. State 10b. County Maryland Prince Geor		Hyat	tsvil					- Civi-	4 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	10d. Inside City Limits 1 X Yes 2 □ No
	death with ins 23a or instant	Funeral Dir	3114 Lancer Place	as Decedent Ever in U.S.	13. V	20	0782		in? (Spe		U.S	A. Race - Ame	
920	ours after o	þ	1 Never Married 2 Married 1	med Forces? ∑Yes 2 ☐ No ′es, Give WWII ar or Dates:	If	Yes, specify		Mexican, Specify:	Puèrto F	cify Yes or No- Rican, etc.)		Black, White	
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12)		16a Deced (Give i life. D	ent's Usual (kind of work OO NOT use	Occupat done du retired)	ion ring most	of workir	ng		of Business/I ment Pr	inting Office
land 2	e d ia	To Be Co	17. Father's Name (First, Middle, Last) Tommy Edwin Graves	· · · · · · · · · · · · · · · · · · ·	1 2 2 11		1	8. Mother		(First, Middle, Merkle			
, Mary	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Pr. Joseph W. Graves, Jr.	- Son	3400	Tilder	n St	reet,	Bre	Route Number, entwood,		own, State, 2	
Baltimore,	Page nent o	,	20a. Method of Disposition 1 ⊠ Burial ≥ □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	II II OIII SIAIB	Lincol	sition (Name natory or other n Cemet	tery	0	1/10	/2004	Brent		Maryland
ga	permit, Departi Importi any inj	1 1	21. Signature of Finered Service Lights 8	s that caused the death.	47		Ltim	ore A	venu		tsvi	1 Home 11e, M	D 20781
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	se on a line. Myycardial I Due to (or as a conseque)	nfarc							Ц	Approximate Interval Between Onset and Death
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions to Figure 1	Due to (or as a consequen	nce of):								
8/60,	cate be executed physician and the burial-transit	dical Examine	that initiated events c.	Due to (or as a consequen	nce of):								
O. Box 68	death certifi e attending id for use as	Physician/Medl	in the past 12 months?	es, outcome of pregnanc]Live birth 2 □ Fetal de]Pregnant at time of deal]Unknown	eath 3 🗆	Ectopic preg Other (spec					230	. Date of deli	very Day Year
cords, P.	w requires that the s been signed by th should be detache	þ	Part II. Other significant conditions contribution	ng to death but not resulti	ng in the un	derlying cau	se given	in Part I.			_		the cause of death?
Ä	The faw ate has b	Completed								24a. Was an autopsy perform		prior to or death?	topsy findings available ompletion of cause of
or vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospita	I I Inpatient 2 E			Other:	4 🗌 Nurs	sing Hom	(Check only one	nce 6		ify)
	tending death. tor: After the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be	Date of Injury (Month, Day Year) Place of Injury - At home	Bb. Time of Injury	М		t s 2⊡No	0	8d. Describe hove the strain of the strain o			ral Route Number,
	spital or ours afte neral Dir filled in I	ical Certi	4 ☐ Homicide 29a. Certifier 1 ☐ Certifying Physician:	To the best of my knowle	edge, death	occurred at	the time.	date and	place, ar	City or Town,	State)	d manner as	stated.
	To the Hos within 24 h To the Fur completely	Medic	(Check only one) 2 Medical Examiner: One and 29b. Signature and title officertifier	n the basis of examination d manner stated.	and/or inv		i my opin		occurre			gned (Month,	
21	(20)11	2	30. Name and address of person who complete	d cause of death (Item 2	3a) (Type, P		2628	37		J	anua	ry 8,	2004
	Sta	te	Michael Berard, M.D. 31. Date filed (Month, Day, Year) JAN 0 9 2004	32. Registrar's Signatur	θ		e, #	107,	Col	lege Par	ck, N	D 207	740
	Registr	_	JAN U 9 2004	seek to ,	good								

Stephanie C. Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-0128 Unpend Item #23ax27 per me 0827 1/30/04 Las For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:45 P^M Stephanie C. Green January 5, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton If Under 1 Year Prince George's

9. Birthplece (State or Foreign Country) 9122 Fox Park Road 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Months Hours Min 33 152-58-7260 Director Roanoke, 12-05-70 Va. Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Yes 2 No Director Clinton Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9122 Fox Park Road 20735 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) yrs. Computer Analyst Oracle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horace Green Elaine Saunders ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4111 Kilbourne Drive, Ft. Washington, Md. 20744
use of Disposition (Name of Date 20c. Location - City or Town, State Elaine Green Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cem. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-9-04 Brentwood, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home marshal 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Seizure Disorder /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) the a ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 🗆 No Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \square Nursing Home 5 \square Residence expother (Specify) At SCENE Certification: To 1XXes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 Tyes 2 🗌 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral I
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 6, 2004 address of person who completed cause of death Item 23a) (Type, Print) YE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State JAN 1 5 2004 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

74-00203 RJ		1 - For UNPEND ITEM 23a	State of Ma 27 PER ME G	ryland /	Depa Cer	rtment of H	lealth a Death	ind Me	ental Hygi	ene	2004	01345
		Decedent's Name (First, Middle, Lass							2. Date of Deatl	1		3. Time of Death
Physicia		Wanda	Goldsmi	th					Month Januar	Day	Year 2004	0930 A. M
/Medic Examine		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of	f Death	Denider		ounty of Death	
Examin		Prince George's	Hospital				Chever	r1v		Pr	ince G	eorge's
Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign intry) ash., DC
Director		579-92-7967	□M 2GF	42	2 Yrs.	World S Days	110010	J	(Month, Day, Jan. 23,	196	1 Wa	aśh., DC
p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	um or Lor	nation						10d. Inside City Limits
anyla shov	_		_	TOC. City, TO	WIT OF LOC							1√2 Yes 2 □ No
Ba-f-	Director		George's_			Land	over		14/)- Citi-o	n of What Cou	Λ
vith th	Dir	10e. Street and Number	-1- 4 4	lπ2		10f. Zip Code	20785	5	1	_		States
is after death with the Marylan , or itams 23e or 28e-1 show raminer must be notified at	Funeral	2606 Pine Bro	12. Was Decedent I		12 V	Vas Decedent of h			cify Yes or No-		Race - Ameri	
er de Itam	nu	 Marital Status Married 2 Married 	Armed Forces?		IS. V	Vas Decedent of F Yes, specify Cub	an, Mexican,	, Puerto F	Rican, etc.)		Black, White	
irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	••	1	☐ Yes 2🖾 No	Specify:			S	-aaife	erican
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e file al Hy l othe vsnt,	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, N			
vid b Venta	ည	Fredrick H.	Goldsmith	1					Cleo	Jack	son	
2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "nsturat", or Itams 23a or 28a-1 show sumatic event, tra Medical Examiner must be notified at		19a. Informant's Name/Relationship (g Address (Street						
and 2 salth n 27 er tr		Harold A. Goldsm	ith - Brot	2,000								DC 20019
permit. Peges 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "nstural; any injury or other traumatic avent, Ita Medical Exagnes.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	20b. Place cemet	of Dispos tery, crem	sition (Name of natory or other	ce)			20c. Loca	tion - City or T	own, State
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permit. Departr Importa		21. Signature of Funeral Service Licen	see Q -		22	. Name and Addre	ss of Facility	y St	ewart F	uner	al Hom	e
8 9 E 2 8		John T. Il	ewart, 1	11		4001 Be	nning	Rd.,	N.E. W	ash.	, DC	20019
		23a. Part1./Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lir	the death. Do	o not ente	er the mode of dyin	ng, such as o	cardiac or	respiratory arre	st,		Approximate Interval Between
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/Medical		resulting in death)	Due to (or as	a consequenc	e of):							
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e deg	sic	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death	5 ∐	Other (specify) _						,
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signe d be c		Part II. Other significant conditions of	satisfied to double of	at not resulting	<i>y</i> 111 (110 G)	outlying outlies go			1 □ Ye	_		bably 4 □Unknown
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The cate t	Con								perform 1 X Yes 2	No	death?	2 🗆 No
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or Al	rtiff	4 Homicide determined	building, et	c. (Specify)	iarm, stre	eet, factory, office		1	City or Town		varnoer or nar	ai noule ivanioei,
pital ours a erel I		20a Cartifior 1 Cartifying Ph	ysicien: To the best	of my knowled	lae death	a coursed at the tr	me date and	d place, a	nd due to the ca	1150(5) 25	nd mannar as r	stated
Hos 24 ho Fun tely 1	edical		niner: On the basis of and manner sta	examination a								
To the Hospital or Attending Physician: The within 24 hours after death. To this Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and mailing 50			29c. Licens	e number		29	d. Date s	signed (Month,	Day, Year)
F ¥ F 8		Particula	, O NC	1		O.C	.M.E.				ary 9,	
		30. Name and address of person who		eath /Item 22-	a) (Type	Print)		<u>_</u>				
		2ABILICA H	Al i	oau (II o III 238	z/ (1ype,	111 Pe	enn St	reet	, Baltir	nore,	, Maryl	and 21201
Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1.	· .						
510		JAN 1 5 ZUU4	Market	1.	1254							

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar				nd / Depa		of H	ealth a		ental Hy		20	04	0134
	*		1. Decedent's Name (First, Midd	lle, Last)							1	2. Date of De Month	ath Day	,	Yeer	3. Time of Death
	Physici		Edward Wil	1iam	Gree	n						Januar			04	3:32 A
	/Medic		4a. Facility Name (If not institution	on, give st	reet and num	ber)		4b. City, T	own, or	Location of	Death		4c.	County	of Death	
	Examin	•	Prince George	's H	ospita	1 Cent	er	Ch	evei	1y			F	rinc	e Ge	orge's
œ.	Funeral Director		5. Sociaf Security Number 207-24-1725	6. Sex	M 2 F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs. 8	B. Date of Bir (Month, Da Apr. 20	th 17, Year) 3,19	31	9. Birthp Cour Peni	olace (State or Forei otry) nsylvania
79			Usual Residence of Decedent			100.0	ity, Town or L	nontine.							1	Od. fnside City Limi
2	h p	<u>ب</u>	10a. State 10b. Count			100.0	•								1.	1 □ Yes 2 □X
2	Ba-f	cto		e Geo	orge's		Bowi						100 03	izen of W	hat Caus	
Ę	0r2	E C	10e. Street and Number					10f. Zip (0716					riat Cour	шуг
5	s 23	ra	15736 Point		Loige Dr 2. Was Dece		118 13	Was Decade		0716	in? /Snec	ify Yes or No		USA 14. Bace	- Americ	can fndian,
90 10	Te Te	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Ma		Armed For	ces?	0.3.	If Yes, specif	y Cuba	n, Mexican,	Puerto R	ify Yes or No ican, etc.)			, White,	
36	P. E.	, Y	3 Widowed 4 Divorce		1 □XYes If Yes, Give Year or Da	tes: 195	1-54	1 ☐ Yes 2	ΩXNο	Specify:				Specify:	Whi	te
5-0036	불	ted	15. Decede	nt's Educ	ation	175	16a. Dece	dent's Usual	Occupa	ation	ad considera	_	16b. K	ind of Bu	siness/In	dustry
21215-0036	Medi	Completed	(Specify only high Elementary/Secondary (0-12)		College (1-	4or 5+)	life.	kind of work DO NOT use	retired))	or working	g				
21.5	the state	E	Elementary/Goodingary (5 12)		1		Te	chnici	an					S. G		
ב	othe vent,	BeC	17. Father's Name (First, Middle	, Last)					İ	18. Mother	's Name	(First, Middle	, Maiden	Sumame	9)	
Maryland	Aenta	To E	Reginald E. G	reen						Ther	esa I	Bartot				
ar)	and a		19a. Informant's Name/Relation	ship (Typ	e, Print)							Route Numb				Code)
∑ ;	n 27		Jo Ann Green /	spot	ıse					Ridg		. Bow				
Baltimore,	to the fit and Mental Hygiene. If item 27 is marked other than "natural; or items 23a or 28a-f ahow or other traumatic event, it a Medical Examiner must be rutified at		20a. Method of Disposition 1	3 □ Be	emoval from S	State	Place of Disponentery, cre	matory or oth	er plac	1	Da		20c. Lo	ocation - (City or To	own, State
Ĕ	ortant: for sortant:	'4 □Donation 5 □ Other			La	kemont	Mem. (ard	ens	1-5-2	2004	Dav	idso	nvil	le, MD.	
<u>a</u>	Department of Health a Important: If Item 27 Is any injury or other tra		21. Signature of Funeral Service	e Licens	(*)	00		2. Name and			200	a11 Fu				
00 8	SOE SO		1 Chu	an	Towa	y						Bowie		. 20	0715	Approximate
	hysician /Medical xaminer	ner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	st only on	Due to (Myclar consecution as a	iral	Infarc Tiny Mellit	tion							Interval Between Onset and Death hour > yeur>
x 68/60,	attending physician and for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	J c	Due to (Diabe or as a conse	equence of):	Mellit	V:5							20 years
о В	y the attendi	by Physician/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23		irth 2 ☐ Fe ant at time of	tal death 3	□Ectopic pre □ Other (spe						23d. Date Mon		Day Year
	been signed by the should be detached		Part II. Other significant condi	tions con	tributing to de	eath but not re	esulting in the	underlying ca	use giv	en in Part I.			/			he cause of death? pably 4 Unknow
O S	8 V N	Completed										24a. Was		24b. V	ere auto	psy findings availal mpletion of cause of
ž ž	te has	E										perfo	ormed2	d	eath?	
ta	certificate ha	BeC	25. Was case referred to media	al						26. Pface	of Death	(Check only				
>	s certific director.	To B	examiner? 1 ☐ Yes 2 ❤️No	Н	ospital:	npatient 2	☐ ER/Outpatie	ent 3 DO	Oth	er: 4 Nur	rsing Hom	e 5 Res	idence	6 □Othe	r (Specii	(y)
Division of Vital Records,	h. After th funeral	atlon: T	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	ding stigation	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time of Injury	of 28	ic. Injun Wor 1 🗆	yat k? Yes 2 □ N		8d. Describe	how infu	ry occurre	∍d	
Divis	after Direction by	Medical Certification:	3 Suicide 6 Coul dete	d not be mined	28e. Place buifdir	of Injury - At ng, etc. (Spe	home, farm, si city)	treet, factory,	office		2	8f. Location (City or To	Street ar	nd Numbe	or Rura	al Route Number,
أسر	othe functions of the Funeral ompletely filled	edical	29a. Certifier 1 Certific (Check only 2 Medic one)	ring Phys at Exemin	sician: To the ner: On the ba and mann	asis of exami	nowledge, dea nation and/or i	th occurred a nvestigation,	it the tir in my o	ne, date and pinion, deat	d place, ai h occurre	nd due to the d at the time,	date and	d place, a	nd due t	the cause(s)
ز	within 2 Fo the I	Σ	29b. Signature and title of certi	ier	MO			29c.	Licens	e number			29d. Da	te signed	(Month,	Day, Year)
6	Va		Min	W	MD			P	50	343			Jan	nuny	2,	2004
1	9		30. Name and address of person KEIVIN B. HG	0.4		e of death (It	em 23a) (Туре Н ч и П	Print)	ent	er E) sive	# 20	Í.	Boive	د , ۱	2004 Acryland ²⁰
8	St	ite	31. Date fifed (Month, Day, Ye.	ar)	32. R	egistrar's Sig	nature									

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 12, **Physician** Saphronia 2004^{ar} Javne Harrison Gebuhr 11:30000/Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8396 Fordham Court Union Bridge Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. De Month Pay, Year 18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 21 F 85 Officy) 279-01-7482 Director Usuel Residence of Decedent with the Maryland 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at Frederick Maryland Union Bridge 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8396 Fordham Court 21791 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐ Yes ŽŪ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home other 7 is marked other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is markad o Richard Elward Harrison Mary Elizabeth Cormany Department of Health and Milmportant: If item 27 is marl any injury or other traumations. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karla J. Robeson/Daughter 8396 Fordham Court, Union Bridge, Maryland 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Jan 14, 2004 Smithsburg, Maryland *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liver ²² Name and Address of Faction P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 <u>1</u>100706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** len /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as attending a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral i 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation njury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22019 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Llyod E. Halvorson, MD., 1475 Taney Avenue, Frederick, Maryland 21702-5127 31. Date filed (Month, Day, Year) JAN 2 1 2004 32. Regisfrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Oate of Death 3. Time of Death Month **Physician** Year phortal 2004 binuar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day tartorol TOMA Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -9784 1 M 2 F 94 213-52 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "netural", or Items 23e or 28e-f sho traumatic event. the Medical Examinar must be notified at 1 ☐ Yes 2 No **Funeral Directo** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Gi Oua 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3- Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry 15. Decedent's Education Elementary/Secondary (0-12) College (1-4or 5+) eacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental Fig. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Itam 27 is rr any injury or other traurr once. avilalbrace, MI)21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date, 20c. Location - City or Town, State 10 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 104 Harford Memorial Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Address of Facility Largo, Fineral Home 21. Signature of Funeral Service Licenses Berdeen, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown After this certificate has been signed by I funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

The law requires that the deal certificate be executed

Hospital or Attending Physicien:

death.

Director:

within 24 hours a To the Funeral D

with the Maryland

death

e filed within 72 hours after al Hygiene.

Other than "netural, or Ite

Baltimore, Maryland 21215-0036

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Be Completed Certification; To

Medical

1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown

24a. Was an autopsy performe 2 X No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

25. Was case referred to medical

2/7 No

examiner'

1 Yes

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

6055

31. Date filed (Month, Day, Year) State

JAN 2 1 2004

Dementia

5 Pending

investigation

6 Could not be determined

South 32. Registrar's Signature

2 ER/Outpatient 3 DOA

Registrar

			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>		of Health a of Death	nd Me		ene g. No. 2 ()	C	013	1,0
	Physici	an	1. Decedent's Name (First, Middle, Last)	elvin	Haywood	Jr.		- 1	2. Date of Death Month		Year	3. Time of D	
	/Medio Examin		4a. Facility Name (If not institution, give s Holy Cross Hos	treet and number)		4b. City, Tov	vn, or Location of		1	4c. County Mont		11:30 ery	P**
	Funeral Director		5/9-/6-3893	M 2□F	ge (In yrs. last birthday) 47 Yrs.		ear If Under 2 ays Hours	Min.	B. Date of Birth (Month, Day, 4 22 5	Year)	9. Birthp Cour D	lace (State or I	Foreign
	s 1 and 2 should be illed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-1 ehow other treumatic event, Item Medical Examiner must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County MD P • G • 10e. Street and Number		10c. City, Town or Lo		de		10	g. Citizen of \		0d. Inside City 1 XYes 2	
	death with	by Funeral Director	7813 Wynnwood		Ever in U.S. 5 - 2 2 - 7 8	207		in? (Spec		U .	S.	an Indian,	
-0036	hours after turel', or lt	ed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	tf Yes, Give Year or Dates:	4-25-84	I ☐ Yes 2 ☐	No Specify:			Specify 6b. Kind of 8		Black	
Maryland 21215-0036	ad within 72 giene. er then "na t, II a Medis	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give life. L	kind of work d OO NOT use re	one during most etired) Handlin		7	Gover			
ryland	hould be file d Mental Hy marked oth matic even	To Be	17. Father's Name (First, Middle, Last) Samuel M. Hay 19a. Informant's Name/Relationship (Typ.			a Address (St		rle	First, Middle, May Wilk:	ins		0-4-1	
re, Ma	is 1 and 2 s of Health an item 27 is r other treur	ĺ	Helene Y. Haywo	od-Spor		Wynnv	wood Dr		Clinton		207	35	
Baltimore,	permit. Pages 1 and Department of Heali Importent: If item 2 any njury or other Once.		1 Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		MD Vete	rans (. Name and A	Cem I		tte & A		. Fu	•	Hm.
	90 5 2 9		23a. Part 1. Ententhe disease, or complice shock, or heart failure. List only on	ations that caused e cause on each li	-0-0		28th St dying, such as c				0018	Approximate Interval Betwe	
9	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)	Due to (or as	r Failure a consequence of): static Pa	ncrea	tic Car	ocer				Onset and De. 1 mont	t h
	cuted nd ransit	Examiner	Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):							2 year	U
8760,	icate be executed physician and s the burial-transit	dicai	resulting in death) Last	Due to (or as	a consequence of):	·							
.O. Box 6	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached tor use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetat death 3	Ectopic pregn Other (specify				23d. Dat Mor	e of delive	ry Day Yea	ar
ords, P.	w requires that been signed to should be det	ĝ	Part II. Other significant conditions con Hepatitis		out not resulting in the ur	derlying cause	e given in Part I.					e cause of dea ably 4 □Unk	
al Reco		Completed	Diabetes						24a. Was an autopsy performe 1 - Yes 2 D	id?	rior to con leath?	esy findings available for the second	ailable se of
Division of Vital Records,	Attending Physicien: The lar r death. ector: After this certificate has by the funeral director, page 2	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	ospital: 1 XInpatie 28a. Date of Inju (Month, Da			26. Place of Other: 4 \(\sum \) Nurs Injury at Work?	sing Home	Check only one) 5 ☐ Resident d. Describe how)	
Divisio	i giệ c	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of tnj building, et	ury - At home, farm, stre c. (Specify)		1 □ Yes 2 □ No		f. Location (Stre City or Town, :	et and Numbe State)	er or Rural	Route Numbe	ır,
	24 h	edical	(Check only 2 Medical Examin	ician: To the best er: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	estigation, in n	ny opinion, death	place, and occurred	d due to the cau at the time, date	se(s) and ma and place, a	nner as sta and due to	ited. the cause(s)	
0	To the within To the Comple	Σ	29b. Signature and title of certifier	June	llms	D 3	35996		29d	1. Date signed	•	ay, Year)	
	Sta	te	30_Name and address of person who con Linda M. Burrel 31. Date filed (Month, Day, Year)	1, MD 2	2730 Univ	ersity	Blvd.	#40C), Whea	iton,	MD 2	20902	
DIL	Registr		JAN 0 8 2004	Block	& Speed								

			1_ For		-		lealth and I	Mental Hygie	ne	. 01050
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	unicate of	Death	Reg.	No. C. U U .	3. Time of Death
	Physicia	an		lman				Month	Day 200	4 11:23 P M
			4a. Fecility Name (If not institution, give			45 Chu Toum	al eastion of Dooth	January	4c. County of Dee	·
barrows, militate be executed be executed by a permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland beautified and beautified and an important: If itam 27 is marked other than "natural; or items 23a or 28a-1 show about a page. Important: If itam 27 is marked other traumatic event, the Medical Examiner and be notified at a page. To Be Completed by Funeral Director	Doctor's Community				or Location of Death anham	1				
			5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year		8. Date of Birth	Q Ri	George's
			507-68-1927	M 2[X]F	54 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Sept. 7,	1949 N	nthplece (Stete or Foreign country) ebraska
	and w		Usual Residence of Decedent 10a, State 10b, County	Ţ,	10c. City, Town or Lo	cation				10d. Inside City Limits
	daryli sho	ō	Maryland Prince G			erdale				1 AYes 2 No
	28a-	ect	10e. Street and Number	eorge s	KIV	10f. Zip Code		100	Citizen of What C	ountar?
	with the contract of the contr	ā	5216 57th Avenue				737			odnay.
	heath ms 2:	era		12. Was Decedent Ev	er in U.S. 13. \			pecify Yes or No-	U.S.A.	ericen Indian,
0	riter	필	1 ☐ Never Married 2 🔯 Married	Armed Forces? 1 ☐ Yes 2 ☒ No			lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black, Whi	ite, etc.
3	urs a	by	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates:		1□Yes 2Ã No	Specify:		Specify: W]	nite
ဥ	72 ho	ted	15. Decedent's Edu (Specify only highest grade		16a. Deced	dent's Usual Occup	pation during most of wor d)	tring.	o. Kind of Business	/Industry
7	thin 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			d)	Allig		
	ed wi	So	,	1	Para	alegal			FBI	
	be fill d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Mai	,	
Ž		၉	Harold Weber				Mari			
<u>Ja</u>	2 sh and 1s m	1	19a. Informant's Name/Relationship (Ty. Robert E. Hallman					ral Route Number, Co		Zip Code)
	l and lealth im 27 her t			nasbana		Contract of the Contract of th		rerdale, MI		Town Chair
0	ges it of the Mittages or ot		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐R	emoval from State	20b. Place of Dispo			0.4000.	. Location - City or	
			'4 □ Donation S □ Other (Specify)		Emmanuel Lu		- 1		_	Nebraska
n n	Depar mpo mpo iny ir		21. Signature a Funeral Service Licental	11/	22	. Name and Addre	Ga:	sch's Fune	ral Home	
	40200	-	Butter W	May				nue, Hyatt		
			23a. Part1. Inter the disease, or complishock, or heart failure. List only or	ne cause on each line.				or respiratory arrest,		Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)	r	nced Li	ver Dis	sease			Many yes
			//	Due to (or as a	consequence of):					
		6	Sequentially list conditions	Due to (or as a	consequence of):					
	nsit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	al-tra	xai	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
3	sicial sicial			1						
9	ificati g phy as the	edi								
X Q Q	ndin use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		ne			23d. Date of de	livery
ă	death e atter id for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tir]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
5	y th	hys	9 Unknown	9□ Unknown						
ığ.	requires that een signed b hould be deta	by P	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause grv		23e. Did tobac	co use contribute to	o the cause of death?
coras	v require been sig should b	edi	Peptie Vleer	Longo	10 paray	1 Lmn	une	1 🗆 Yes	2 ☐ N o 3 ☐ P	robably 4 Unknown
	> 0 0	Completed	Deficiency, Ce	110/14:	5.			24a. Was an	24b. Were a	utopsy findings available
Ľ	0 - 0	Eo					· · · · · · · · · · · · · · · · · · ·	autopsy performed	2 death?	completion of cause of
Vital	sicien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only one)	140	2010
	Physici this ce al direc	To B	examiner?	lospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Oth	er: 4 🗌 Nursing H	ome 5 Residence	6 □Other (Spe	icify)
0	Attanding Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)		28c. Injur Wor	y at	28d. Describe how i		
UNISION	andir path. or: Af	atic	2 Accident investigation				Yes 2 □ No			
Š		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injun- building, etc.	 At home, farm, stre (Specify) 	eet, factory, office		28f. Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
	ital o			1						
	s Hospital or 24 hours afte Funeral Dir letely filled in	Medical	(Check only 2 Medical Examin	sician: To the best of ner: On the basis of e	xamination and/or inv	occurred at the tir	me, date and place, pinion, death occur	, and due to the cause rred at the time, date	e(s) and manner as	s stated. to the cause(s)
	To the within 2 To the I complet	Ned	one)	and manner state	d.					
	S S S S S S S S S S S S S S S S S S S		29b. Signature and title of certifier	Lit ,	MM	29c. Licens	3/001	290.	Date signed (Mont	
	(00)			\tag{'}	· · · ·					
/	(20)		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print) 2500	on holl	MADO	270	r. #430
	~	10		32. Registrar	s Signature	9.07	- 10000			
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 0 9 2004	Z.	4 1					

Consider Name of the Anthone, you ware and name of the Control o				1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artment of H	ealth ar D <i>eath</i>	nd Mental H	ygiene 2	004	0 35
Eminator Figure 1 Figure 2 Figure 2 Figure 2 Figure 2 Figure 2 Figure 2 Figure 2 Figure 3 Figure 3 Figure 3 Figure 3 Figure 4 Figure				Decedent's Name (First, Middle,	Last)						Death		3. Time of Death
#4 - Sealty former (incoming or passes and number) #5 0972 Beld fell burg Road 1.0 april				Ernest Freder:	ick Hauser,	Jr.				Januar	cy 4, 20)04	3:20 p M
Section Control Cont				4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of I	Death	4c. Cour	nty of Death	· · · · · · · · · · · · · · · · · · ·
Second Security Numbers Size Second Security Numbers Size Second Security Numbers Size Second Security Numbers Size Second Security Numbers Size Second Sec				6902 Heidelburg	g Road			Lan	ham		Pri	nce Ge	eorge's
Sept. 4, 1917 Mashington, D.		Funeral		5. Social Security Number	6. Sex 7. Aq	e (in yrs. la	st birthday)	If Under 1 Year	If Under 24	Min (Month I	lirth		
100. State 100. County 1				577-12-0878	1.∆M 2 F	86	Yrs.	Month's Days	Hours	Sept.	4, 1917	Was	hington, DC
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Janet A. Mason - Daughter 6902 Hefdelburg Road, Lanham, MD 20706 200 Method of bepason 1 April 2 (Comments of 20 methods) 21 Synaphic of phosps is songle is songle in the mode of dying, such as cardiac or respiratory arrest. 22 Name and Address of Foility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23 April Fere by blesses, or complications and contributing to death or season with a cause of death (law pink) 24 Synaphic of phosps is songle is songle in the mode of dying, such as cardiac or respiratory arrest. 25 April Fere by blesses, or complications of the mode of dying, such as cardiac or respiratory arrest. 26 April Fere by blesses, or complications of the mode of dying, such as cardiac or respiratory arrest. 27 April Fere by blesses, or complications of the mode of dying, such as cardiac or respiratory arrest. 28 April Fere by blesses, or complications of the mode of dying, such as cardiac or respiratory arrest. 29 April Fere by blesses, or complications of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying, such as cardiac or respiratory arrest. April Ference of the mode of dying arrest arrest arrest arrest arrest arrest arrest arrest arrest arrest arrest arrest arrest arrest a	>	hould d Me mark matic	ĭ		1		10b Mailin	a Address (Street e					
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22. Name and Address of Facility 23. Spars of Shore Training Service Training Service Training Service Training Service Training Service Training Service Training Service Training Service S	ਠੁ			1 Burial 2 □ Cremation	B □Removal from State	Cei	metery, cren	natory or other place	· 1				
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ACUTE Delirium Program	g	permii Depar Impor any ir	P.	21. Signature of Fineral Service Li	May					Gasch's Hy	uneral attsvil	Home, Le, MI	P.A. 20781
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The state of the s			ē	Sequentially list conditions, if any, leading to immediate									
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FFEMALE: 23d. Date of delivery 23d. Date of deli	S.	exec an an rial-tr	Exa		Due to (or as	a conseque	ence of):						
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			1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of H			giene ()	04	01352
		₹:	1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		Athena Hrones	Heddinger				January	y 1 20	004	7:35 A M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		Death	4c. Count		
			Anne Arundel Medi			Annap If Under 1 Year		t Hrs. I a Day (B		Arui	
П	Funeral Director		5. Social Security Number 6. Security Number 11	X ☐M 2X☐F 7. Age	e (In yrs. last birthday) 74 Yrs.	Months Days	Hours	Min. 8. Date of Bir	, 1929	9. Birth	place (State or Foreign Ntry).
			Usuel Residence of Decedent			1	<u> </u>	1000.	,1,2,	Webi	- VA.
	ylanc how		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	e Ma-fe	cto	MD Prince Ge	orge's	В	owie					1. Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	s 23e	rai	12114 Millstrea		110			0715	USA	4	
	er de Items	by Funerai	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent B Armed Forces? 1 Yes 2 A	ever in U.S. 13.	Was Decedent of F If Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Ha	ce - Americ ck, White,	
38	urs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🖾 No	Specify:		Specia	y: Wh:	ite
ŏ	iled within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f ehow ont, I'ra Medical Examinar must be notified at	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	of working	16b. Kind of B	lusiness/ln	dustry
2	thin 7	npie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired	d)	or working			
7	ed wi ygien rer th	Completed		2		Admin. As			Govern		
ğ	be fill hd off	Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle,			
2	d Mer narke natic	ဥ	Angelo Hrones 19a. Informant's Name/Relationship (7)	ima Printl	10b Maili	na Address /Street		en Aganosto or Rural Route Numbe	-		Code
Z Z	d 2 sl th an t7 le r traur	ľ	Richard Heddinger			4 Millstr					(Code)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merial Hygiene. Department of Health and Merial Hygiene. The marked other than "natural" or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition	-	20b. Place of Dispo			. Bowie M	20c. Location		own, State
ē	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metropoli		,	-3-2004	Alexand	ria	VΛ
Baltimore, Maryland 21215-0036	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licen		22	2. Name and Addre	ss of Facility	Beall Fun	neral Ho	me	VII.
m	Depa Impo		Brian	Towell				y. Bowie,		0715	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do not ent	er the mode of dyir	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition	Scp	tic She	ock					Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
п	Examinic:	_	Sequentially list conditions,	b. Pn-e	norsecuence of	_					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to himbediate cause. Enter Underlying Cause (Disease or injury	One is (or as	a con section to on.						
	execunate and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cail		d							
9	tificate ng phys as the	Physician/Medicai									
Вох	eath certific attending p	an/N	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy	,			ite of delive	,
О.	e dea tha at ned fo	sici	in the past 12 months? 1 🗆 Yes 2 V No	4□Pregnant at 9□ Unknown		Other (specify)			Mo	onth	Day Year
<u>Р</u>	uires that the dei n signed by tha a ld be detached f		9 ☐ Unknown Part II. Other significant conditions co	entribution to death bu	it not resulting in the u	ndarhina cauca an	en in Part I	23a Did t	obacco usa con	tribute to th	ne cause of death?
S,	signe	1 by	Haratrophic Obst	versting to dealing	cogiomes	and his	entini Fanti.		Yes 2 □ No	3 ☐ Prob	b
Ö	w requir been si should I	etec	10 1 2 1 2 .	0 11	94						
Rec	has ge 2	Completed	THATCOCOCI	of Breman	Se .			24a. Was autor perfo	osy	prior to coldeath?	psy findings available mpletion of cause of
Division of Vital Records,	sicien: The law s certificate has b lirector, page 2 s		25. Was case referred to medical				Of Disco	1 Tyes	2√2No		2 No
₹	Attending Physicien: ir death. ector: After this certifice by the funeral director.	To Be	examiner?	Hospital:	nt 2 ER/Outpatier	nt 3 DOA Oth	1-15-1	of Death (Check only of ing Home 5 ☐ Resid		ar (Specif	<i>(</i>)
10	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time o			The state of the s	how injury occur		//
Ö	ttendin death. ctor: Aft / the fun	atio	1 Natural 5 Pending 2 Accident investigation	(MOIIII, Day	rea/ injuly		Yes 2 □ No				
N N	I or Attendater deatl	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str	eet, factory, office		28f. Location (S City or Tox		ber or Rura	l Route Number,
	ospitel o hours aft unerel Di ily filled in			1							
	T 4 IT 0	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and made, date and place,	anner as si and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of confifier	and manner sta	180.	29c. Licens	e number		29d. Date signe	d (Month,	Dav. Year)
	6 H E H		12/1			Doc	582		1/11	104	
+	(I)		30. Name and address of person who d	completed cause of de	eath (Item 23a) (Type.	Print)					
A.2	7			noc my	D Ann	e Arru	-del	Medical	centr	; An	napolis
	Sta Registr		31. Date filed (Month, Day, Year) \(\) \(ar's Signature	alle)					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	•				2001.	01353
	Physici	an	1. Decedent's Name (First, Middle, L	ast)				Month	Day Year	3. Time of Death
	/Medic	al				4h Cit. Tana aslan		January	1	4:36 рм
	Examin	er							i i	
	Funeral			Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign intry)
	Director		Secretarion Properties Pr			isiana				
	land				10c. City, Town or	Location				10d. Inside City Limits
	Mary I-f sh	tor	MD Calve	rt	St. Leo	nard				1 % Yes 2 □ No
	ath with the Marylan 123a or 28a-f show	Director	10e. Street and Number					10	g. Citizen of What Cou	intry?
	ath wi	rai	6450 Long Beach							
	er des itams	Funeral	11. Marital Status	Armed Forces?		. Was Decedent of Hispai If Yes, specify Cuban, M	inic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)		
336	ours after des raf', or itams Examination	ρ		If Yes, Give Year or Dates:		1 ☐ Yes 2X No Si	pecify:		Specify: Wh	ite
Maryland 21215-0036	72 hc	Completed			16a. Dec	edent's Usual Occupation	n na most of workir	1	6b. Kind of Business/li	ndustry
2	d within 72 giene. ir than "nu Ire Modil	mple	Elementary/Secondary (0-12)	College (1-4or 54	life.	DO NOT use retired)	ig most or works	, g	O II-	
22							Mother's Name	(First Middle M		
and	be do do do do do do do do do do do do do	To Be		•					alden Sumame)	
ary	2 should and Men is marka sumatic	F			19b. Mai				City or Town, State, Zi	o Code)
	₽ = 2 ±		Oliver Eugene Ho	lland/Husbar	nd 6450	Long Beach	Dr. St.	Leonan	1. MD 2068	35
Baltimore,	0 ° ± ≥		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	cemetery, cr	ematory or other place)	1		0c. Location - City or T	own, State
Ē	Pa men ry		*4 □ Donation 5 □ Other (Spec	sify)				04	Strasburg,	VA
Bal	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lic	laun	_ i	Murphy Funer	cal Home	4510 Wi	ilson Blvd.	
Н			shock, or heart failure. List on	mplications that caused to y one cause on each line	the death. Do not e	nter the mode of dying, su	uch as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Provician		disease or condition	a Gal	blado	ler Car	ncer			Onset and Death
Н	/Medical Examiner		and a second sec	Due to (or as a	consequence of):					
		er	Sequentially list conditions, if any, leading to immediate		consequence of):					
	cuted	Examine	that initiated events	c						
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760	# % e	dicai	•	d						
9 X	ath certifica ttending pt or use as tt	/Med	IF FEMALE:	23c. If ves. outcome o	f pregnancy				23d Date of dollar	201
Вох	death atten	cian	in the past 12 months?	1☐Live birth 2	Petal death 3					Day Year
o.	at the de by the a stached	Physician/M		9□Unknown						
ds, P	es this	by	Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying cause given in	Part I.			
Records,	w requir	Completed		· · · · · · · · · · · · · · · · · · ·						
Re	The lavate has	Jup						autopsy perform	ed? prior to co	impletion of cause of
Vital		a)	25. Was case referred to medical			26.	. Place of Death			2 No
ţ	<u>7</u> .e. 7	To B		Hospital: 1 Inpatien	t 2 ER/Outpatie	0.1				(y)
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury					
sio	Attanding r death. ector: After by the fune	catio	2 Accident investigati 3 Suicide 6 Could not	on he			2 No			
Division		Certification;	4 Homicide determine		y - At home, farm, s (Specify)	treet, factory, office	2	Bf. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	To tha Hospital or within 24 hours afte To the Funaral Dir completely filled in	edical (29a. Certifier 1 Certifying F (Check only one) 2 Medicel Exc	Physicien: To the best of eminer: On the basis of and manner state	examination and/or i	ath occurred at the time, dinvestigation, in my opinion	late and place, a on, death occurre	nd due to the cau d at the time, dat	use(s) and manner as s e and place, and due t	stated. the cause(s)
	To tha Ho within 24 To the Fu	Me	29b. Signature and title of certifier	81		29c. License nur	mber	290	d. Date signed (Month,	Day, Year)
_	(1)		1 Janual	Stam	in.	DUS	5092		1/2/20	04
K	1/4/		30. Name and address of person wh	completed cause of de	ath (Item 23a) (Type	303 F	Dinn	For	rich n	10201-
1			31. Date filed (Manufacture)	1 Soud	Sturfe 's Signature —	= 303 F	rince	1100	a p	1/20678
	Sta Registr		JAN 0 6 201	14 Librar	# Lo	will !				

		•	For State Registrar	State of	Maryland / De	partment of herificate of	lealth and	Mental Hy	•	14 0.1354
			Decedent's Name (First, Management)	Viddle, Last)			D G G G G G G G G G G	2. Date of De	ath	3. Time of Death
	Physicia /Medic		Mary	Anna	Haselbe	erger		Month	Day Y	94 5:55 PM
	Examin		4a. Fecility Name (If not insti		oer)	4b. City, Town, o	r Location of Deat	h	4c. County of	
I)			SALRED HE				ERLAN		ALLE	GANY
	Funeral Director		5. Social Security Number 220-03-7261	1□M 2🂢 F	Age (In yrs. last birthda 84 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birl (Month, Da Jun 14	4, 1919	Birthplace (State or Foreign
2	2 *		Usuel Residence of Deceder 10a. State 10b. Co		10c. City, Town or	Location				10d. Inside City Limits
Model	-feho	ţō		legany	Cum	berland				1X□Yes 2□No
t d	or 28e	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	•
4	8 23e	erall		t. Savage Roa			21502		USA	American Indian,
1215-0036	perint. Tages I said. Should be find white 12 flours are locate will be wayful popular rages. Health and Mental Hygiene. Importantis if item 27 is marked other then "natural", or Items 23e or 28e-1 ehow eny injury or other traumatic event, the Medical Exeminer must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo	Armed Force Married 1 ☐ Yes 2	₹ No	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puer Specity:	to Rican, etc.)	Black, Specify:	White, etc.
2-0-2	natur	eted		edent's Education lighest grade completed)	16a. De	cedent's Usual Occup	ation during most of wo	rkina	16b. Kind of Busi	ness/Industry
21215-0036	then then	mpl	Elementary/Secondary (0-		or 5+) waitre	ve kind of work done DO NOT use retired	d)		restauran	•
N 3	Hygic other	o C O	17. Father's Name (First, Min	ddle, Last)	waiti	,55	18. Mother's Nar		Maiden Sumame)	
arylan	Mental Mental arked c	To Be	Henry Burk	hart			Carrie			
ž	auth and n 27 is my ler traumy		19a. Informant's Name/Rela Richard Burk				and Number or Ru	Mt. Sa	er, City or Town, St. avage	MD 21545
Baltimore,	ment of He ant: If iter		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Oth	tion 3 □Removal from Sta er (Specify)	20b. Place of Dis cemetery, c SS Peter a	position (Name of rematory or other place and Paul Cem	netery	1/12/2004	20c. Location - Ci	
Balt	Department Important: If eny injury o		21. Signature of Funeral Ser	rvice Licensee	11:	22. Name and Address	i ซีโก๊ติซัลเ H	ome, PA		
			23a, Part1, Enter the disease	se, or complications that cau	especial Do not a				land, MD 21	502 Approximate
			shock, or heart failure. Immediate Cause (Final	List only one cause on eac	ngestive 1				1031,	Intervat Between Onset and Death
	hysician /Medical		disease or condition resulting in death)		as a consequence of):	rem ja	ince			6 menths
E	xaminer		Sequentially list conditions,	b						
7	Sit S	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					
760,	hysician and the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence of):			-,		
1760,	ysiciar e buri	cal		d						
68	as th		IS FEMALE.							,
Records, P.O. Box 68	signed by the attending ph d be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?	1 Live birti	n 2 Fetal death :	3 □Ectopic pregnancy	,		23d. Date of Month	
P.O. E	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnan 9□Unknow		5 ☐ Other (specify) _			Wioriti	Day 16al
م َ	ned by detac	y Ph	Part II. Other significant con	nditions contributing to deat	h but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
rds	been sign	q pa						1 🗆 Y	'es 2 □ No 3	Probably 4 Unknown
900	has been ge 2 should	Completed						24a. Was autop		re autopsy findings available in to completion of cause of
<u>~</u>	ete ha	Com						perfor	med? dea	
of Vita	sertific ector.	Be	25. Was case referred to me examiner?	Hospital:		04		ith (Check only o	ne)	
Of O	this (7	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	- Y		4 Nursing n		ence 6 Other owningury occurred	(Specify)
ion	ith. : After	atlon	1 Natural 5 □ Po		Day Year) Injun	Worl	k?¨ Yes 2 □ No	200. 0000.00 11	ow injury occurred	
Division of Vital Records,	er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ C	ould not be 28e. Place of building	Injury - At home, farm, , etc. (Specify)	street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	irs aft ral Di									
Division	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical	one)	tifying Physicien: To the be licel Exeminer: On the basi and manner	s of examination and/or	investigation, in my of	pinion, death occu	irred at the time, o	date and place, and	due to the cause(s)
٩	Zo To Co	Σ	29b. Signature and title of ce	refullin		29c. License			29d. Date signed (A	
			30. Name and address of pe		of death (Item 22a) (To-		55325		Jan 10,	2004
			WONSOCK	1		errace	Frostbi	ne MV	121532	
	Sta	7.4	31. Date filed (Month, Day,)	(ear) 32. Reg	istrar's Signature			0		
	Registr		Jan	2 1 2004	were to	doct :				
DHMI	H 17 Rev 1/20	001			ORIGI					

		4	1 - For State Registrar		State of	Marylar		artmen rtificat			ind M		Reg. No.	2001	01355
	Physici	an	Decedent's Name (First, Mid Robert	tie, Last)	<i>1</i> .	H	licks					Jan 14	Day	Year	3. Time of Death 7:00 am M
	/Medic Examin		4a. Fecility Name (If not instituti Box 11	on, <i>giv</i> e s	treet and num	ber)		Spi	ring (4c. C	County of Dea legany	
	Funeral Director		5. Social Security Number 219-16-4804 Usual Residence of Decedent	6. Sex	(M 2□F	7. Age (In yrs. 79	last birthday) Yrs.	If Under Months		If Under : Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jul 4,	1924	9. Bir	thplece (State or Foreign ountry)
~	Maryland		10a. State 10b. Coun	rrett		10c. Cit	y, Town or Lo	ndsvill	е						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	Funeral Director	10e. Street and Number 2142 Old Mor	ganto	own Roa	ad W		10f. Zip		2153 ⁻	1		10g. Citize	en of What C	ountry?
980	be filed within 72 hours after deeth with the Maryland that Hygiene. Idea other than "naturel, or items 23e or 28e-f ehow event, its Medical Examinat must be notified at	Þ	11. Marital Status 1 Never Married 2 Mi 3 Widowed 4 Divorce	rried	12. Was Deced Armed Ford 1 XYes 2 If Yes, Give Year or Da	ces? 2 🔲 No		Was Decedif Yes, specific Yes		ispanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify: W	
Maryland 21215-0036	e filed within 72 he al Hygiene. other than "natu	Completed	15. Deced (Specify only high Elementary/Secondary (0-12			4or 5+)	16a. Dece (Give life. Teach	kind of wo DO NOT u	al Occup rk done d se retired	ation during most f)	of worki	ing		ic Scho	
land ?	should be filed and Mental Hygin marked other imatic event, iii	To Be C	17. Father's Name (First, Middle Robert W. 1		, Sr.						rs Name	e (First, Middle, Bell	Maiden S	Surname)	
	nd 2 salith ar 27 le		19a Informant's Name/Relatio	ship (Ty)	oe, Print) Wİ		No. of the last of			ganto		Frien			Water Control
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other		emoval from S		Place of Dispondering Creater States of Dispondering Creater S	matory or c	other plac	e, P.A.		1/15/2004		ation - City or esaptov	
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service	Dy	. Sca	rpel	4	10	8 Vir	ginia A	venue	ome, P.A. e; Cumbe	rland,	MD 215	02 Approximate
3760,	death certificate be executed was entireding physicien and attending physicien and for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	st only of	Ends Due to (c	ich line.	oronar quence of):								Interval Between Onset and Death One year
O. Box 6	thet the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		nth 2 ☐ Feta unt at time of o	aldeath 3	⊒Ectopic p ⊒ Other (sp		,			23	3d. Date of de Month	olivery Day Year
s, P	sign d be	þ	Part II. Other significant cond	tions cor	tributing to de	ath but not res	sulting in the u	inderlying o	ause giv	en in Part I.			obacco us res 2 🖔		o the cause of death?
of Vital Record	The law ate hes b page 2 s	Completed										24a. Was autor perio 1 \(\text{Yes} \)		24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \square No
	Attending Physiclen: Trideath. It death. ector: After this certification the funeral director, pi	tion; To Be	25. Was case referred to mediexaminer? 1 Yes 2 No 27. Mapner of Death 1 Naturel 5 Pen 2 Accident inve	H	lospital: 1 In In 28a. Date o		ER/Outpatier 28b. Time o Injury		28c. Injun Wor	er: 4□ Nu	rsing Ho	n <i>(Check only o</i> me 5 ☐ Resid 28d. Describe I	dence 6		ecfy)son's home
Division	2 5 4 6	Certification;	3 Suicide 6 □ Cou	d not be mined	28e. Place of building	of Injury - At h g, etc. (Speci	ome, farm, st	reet, factor	y, office			28f. Location (: City or Tox		Number or R	lural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the funeral process.	Medical C	29a. Certifier 1 (Check only 2 Medicone)	ring Phys al Exami	sician: To the laner: On the ba	sis of examina	owledge, deat ation and/or in	th occurred ivestigation	at the tir i, in my o	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To the comp	Σ	29b. Signature and title of cert	1//	2007	111	1110	29		e number					th. Day, Year)
,			30. Name and address of person	n who co	mpleted cause	of death (Ne	m 23a) (Type,	Print)	D22	181			Jan	uary l	4, 2004
			Gary Wagoner	M	925		n Wals		ve;	Cumbe	rlan	d, MD	2150	2	
	Sta Regist		31. Date filed (Month, Day, Ye JAN 2 1	2004	Alle	Www St	ature de la constant	E							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:36 AM **Physician** 2004 RUBY ANN HURLEY anuney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Min. Months 1 □ M 2 🖾 F Yrs. SEP.27,1946 EMMITSBURG, MD. Director 215-44-9541 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f shov the Medical Examiner must be restilist at 1 ☐ Yes 2 No Director SABILLASVILLE FREDERICK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21780 U.S.A. 238 16931 RAVEN ROCK RD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:WHITE Completed by 3
☑ Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, III 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARRIE TURNER MELVIN STOUTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7943 MONN DRIVE, WAYNESBORO, PA. 17268 MICHAEL HURLEY, SR. / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or FRIENDS CREEK CEMETERY 1/16/2004 EMMITSBURG, MD. 21727 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME Riles EMMITSBURG, MD. 21727-0427 210 W. MAIN ST., Pant/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Deay Immediate Cause (Final disease or condition resulting in death) Physician 20 4mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the attending physician and ned for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760. the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown ğ 23e. Did tobacco use contribute to the cause of death? Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by pe 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed" 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 wpatient 2 No: 2 ER/Outpatient 3 DOA 10 1 Tes 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32% agistrar's Signatu 31. Date filed (Med State Registrar

IN HESS	•	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2004 0 358										
Physicia								JAN • 3				
/Medica Examine		4a. Facility Name (If not institution, give street and number) 102 EAST APPLEBY AVENUE				4b. City, Town, or Location of Death CAMBRIDGE				4c. County of Death DORCHESTER		
Funeral Director		5. Social Security Number 214-07-8359 6. Sex. 11 M 2□ F 7. Age (In yrs. last to 1.0 M 2□ F 84				Months Days Hours Min. (Month, Day, Year)					rthplace (State or Foreign country) ryland	
aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 Yes 2 □ No	
the M.	recto	Maryland Dorche 10e. Street and Number	ster	Ca	ambri	dge 10f. Zip Code			10	g. Citizen of What C	/-	
s 1 and 2 should be filled within 72 hours after death with the Maryland if Healith and Membal Hygiene. A filled in the filled within 72 hours after death with the Maryland if Healith and Membal Hygiene. Other traumatic event, the Medical Examinating the Lydflind at		102 E. Appleby Avenue				21613				USA		
	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	t Ever in U.S. ?] No :	. 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc				fy Yes or No- can, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White			
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				lent's Usual Occu kind of work done DO NOT use retire	during most (ed)	of working	, 1	16b. Kind of Business/Industry Wire		
	To Be Co	17. Father's Name (First, Middle, Last) Enos Elias Hess					18. Mother's Name (First, Middle, Maiden Sumame) Mary Naomi Bradley					
alth and 1		19a. Informant's Name/Relationship Sharon L. Born/			561	3 Bayber	ry Way			City or Town, State, MD 2161.		
permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other trai		1 MBurial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)						Oc. Location · City or Town, State Hurlock, MD				
permit. Departm Importe any inju		21. Skyleture of Funeral Service Licensee 22. Name and Address of Facility Current romwell Funeral Hone, F.A. 308 High St., Cambridge, MD 21613										
Physician		23. Part Enter the disease or complete that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									Interval Between	
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Shut the Doved of Abdenier Due to (or as a consequence of):										
ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
9 % e		IF FEMALE:	d	se of pregnancy	y					23d. Date of de	elivery	
the death or the attention of the attent	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 25b Nysol-School of Pestal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy 5 Other (specify)							Month			
The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as it	کر ا	Part II. Other significant conditions contributing to death but not resulting in the under								d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
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the Hospitel or Attending Physicien: The lar in 24 hours after death. The Funeral birector: After this certificate has inpletely filled in by the funeral director, page 2	Be	25. Was case referred to medical examiner? 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation 28b. Time of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Injury (Month, Day Year) 28d. Time of Injury at Work? 28d. Injury at North									AII COTTATE	
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To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertification;	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office City or To						City or Town	Street and Number or Rural Ryste Number wn, State)			
Hospite 24 hours Funeral etely filled	edical C	29a. Certifier (Check only only only only only only only only										
To the vithin To the compl	Me	29b. Signature and title of certifier				29c. License number O.C.M.E			29	29d. Date signed (Month, Day, Year) JAN 4, 2004		
		30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201										
Sta Registr		31. Date filed (Month, Day, Year)	the contract of the contract o	d's Sig	سي	1 4						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Day Year **Physician** :00 gm Helen Margaret Hoggard 2004 Chuch 6 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Stella Maris at Mercy Baltimore City 8. Date of Birth (Month, Day, Yeer) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1□ M 20XF Yrs. 63 Director Sept. 13, 1940 514-40-5827 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10a, Stete 10b. County 10c. City, Town or Location tam 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Madical Examiner must be notified at 1 X Yes 2 □ No Funeral Director Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1236 Washington Blvd. 21230 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 1 ☐ Yes 2 ☑ No Specify: 9 3 ☐ Widowed 4 ♥ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfield Scott Morgan Anna May Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cathy Stanley/daughter 24 Virginia Ave. NW Glen Burnie, MD 21061 20b. Place of Disposition (Name of 20a. Method of Disposition Jan. 7, 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 2004 Baltimore, Maryland 22 Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens Jule 1701251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical cance Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law raquiras that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Officer (Specify) ٩ 1 ☐ Yes 2 ☐ No Director: Aftar this d in by the funaral di 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred edical Certification: 5 Pending investigation 1 Naturel daath. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2007 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Sepet Baltimore 31. Date filed (Month, Day, Year) 32. Registre's Signature State 2003 ▶ Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 8 2004

ORIGINAL

32. Registrar's Signature

		1 - For State Registrar	State of Marylan		artment of I			ene g. No. 200	14 01361
		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
Physic /Medi		Sarah Doris Je	efferson				January	3, 2004	12:30 p M
Examir	ner	4a. Fecility Name (If not institution, give s				or Location of Deat		4c. County of E	
		Heartland Health (5. Social Security Number 6. Sex		last birthday)		attsville		Prince	e George's Birthplace (State or Foreign
Funeral Director			м 2 D F 78	Yrs.	Months Days			1925 T	Country) Cennessee
70		Usual Residence of Decedent							
arylar show	-	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☑Yes 2 ☐ No
he Mi 28a-f	Director	Maryland Prince Ge	orge's	Hyatts	Ville 10f. Zip Code		10	g. Citizen of Wha	
with Se or		3111 Lancer Place	2		2078	82		U.S.	•
be filed within 72 hours after death with the Maryland lat Hygiene. Id elygiene. Id other than "natural", or items 23e or 28e-1 show event, Ire Madical Examiner must be notified at	Funeral		2. Was Decedent Ever in U.	.S. 13.			Specify Yes or No- to Rican, etc.)	14. Race - A	American Indian,
after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ∐Yes 2 M∭No If Yes, Give		r Yes, sp <i>ec</i> iry Cub 1 ☐ Yes 2 💆 No		to Hican, etc.)	Specify:	Vhite, etc.
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withii iene. than	m o	Elementary/Secondary (0-12)	College (1-4or 5+)		lerk	-,		ry Clear	ners
e filed Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M		
uld be Vlenta Vlenta urked	To E	Joseph Foster				Eliza	ibeth Le	wis	
2 should and Mer is marke raumatic		19a. Informant's Name/Relationship (Typ		1			ural Route Number,		e, Zip Code)
C, IV t and Health em 27 ther tr		Denise J. Hunt - D			Lancer P	lace, Hy	attsville Date 2	MD 20 0c. Location - City	782
Pages :		1 Burial 2 □ Cremation 3 □ Re	emoval from State	emetery, crer	natory or other pla	· 1			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			nington Ce	'		Adelphi,	
permit. Departrimporte any inju		1 6 Gut-10	Vlan	100%		Ga	sch's Fun	eral Hom tsville.	ne, P.A. MD 20781
		23a. Part1 Enter the discase, or complice shoot or heart failure. List only on	cetions that caused the duali						Approximate Interval Between
Physician		Immediat Cause (Final disease or condition	Arterioscle	rotic	Cardiova	scular Di	sease -		Onset and Death Years
/Medical Examiner		resulting in death)	Due to (or as a consequence			ocurur bi	Locabe		Tears
CAAIIIIIei	<u>.</u>	Sequentially list conditions, b	Due to (or as a consequ	uance of):					
ted	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that patient of exercises.	Due to (or as a consequ	dence or,					
execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
icate be executed physician and sthe burial-transit	dical	d							
ntifica ng ph	1 40	IF FEMALE:						1	
eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	Ideath 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5∟	Other (specify) _				,
that the de		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
w requires that been signed I should be det	d by	Alzheimer's Disea	ise				1 🗆 Yes	2 ⊠No 3 □	Probably 4 Unknown
aw rec	olete						24a. Was an	24b. Were	a autopsy findings available to completion of cause of
sician: The law scentificate has E lirector, page 2 s	Completed						autopsy perform 1 Yes 2	ed? death	to completion of cause of 1? /es 2 \(\sigma\) No
ian: ian: artifica ctor, ş	Bec	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one		
hysic this ce	은	1 ☐ Yes 2 🛣 No	Annual Control of the	ER/Outpatien	C 3L DOA		lome 5 ☐ Resider		Specify)
fing P	inol.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk? ∣Yes 2 □ No	28d. Describe how	v injury occurred	
ttend death ctor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury - At ho	ome farm str		1162 5 140	28f. Location (Stre	ent and Number o	Rural Route Number,
after after Directory	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	y)	out radiory, office		City or Town,	State)	
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of my kno er: On the basis of examina	wledge, death tion and/or inv	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the cau arred at the time, dat	use(s) and manner te and place, and	r as stated. due to the cause(s)
o the o the o the o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29	d. Date signed (M	onth, Day, Year)
H 3 H ŏ		1 Con O-	Gr. (lex)	m >	OC C	1852	,T,	anuary 5	2004
[7]		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,			3.0	<i>J</i>	
(C)		Paul A. DeVore, M.			Road, H	yattsvill	Le, MD 20	0781	
Sta Regist	ate	31. Date filed (Month, Day, Year) JAN 0 9 2004	32. Registrar's Signa	ture					

			For 1 State	State of Maryland	I / Depa		lealth and	Mental Hyg	iene	
	Physici		1. Decedent's Name (First, Middle, Last)	Jadeson		inicate or	Deain	2. Date of Dea Month	th Day Yes	
,	/Medic Examin		4a. Fecility Name (If not institution, give s Manor Care of Silv 5. Social Security Number 6. Sex	treet and number) ver Spring	st birthday)	4b. City, Town, o Silver If Under 1 Year Months Days		th (4c. County of D	eath
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. Marked other than 'natural', or fleme 23a or 28a-1 show marked other than matter marked other than matter marked other than the marked or in the Medical Exercipation	y Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery 10e. Street and Number 2501 Musgrove Road 11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 29 No If Yes, Give 1	Town or Lo	cation Spring 10f. Zip Code 2090 Was Decedent of H f Yes, specify Cuba		1	0g. Citizen of What USA 14. Race - A Black, W	10d. Inside City Limits 1 □ Yes 2 □ No Country? merican Indian,
Maryland 21215-0036	filed within 72 Hygiene. ther than *nai nt, Ita Medic	Be Completed by	3 Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last)	Year or Dates:	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busine Private	
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Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility Ma		Funera1	Maryland Home of MD 746
760,	Wedical Medical Medical Medical Medical with the print of	cal Examiner	23a. Pan1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unioning Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	nce of):	irdumyo	4	c or respiratory arru	əst,	Approximate Interval Between Onset and Death
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rds, P.	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions con	tributing to death but not result	ting in the u	nderlying cause giv	en in Part I.			e to the cause of death?
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Division of Vital	ding Phys h. After this funeral dir	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 Yes 27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation		R/Outpatien 28b. Time of Injury	28c. Injun World	er: Mursing H		e) ince 6 ⊡Other (S ow injury occurred	pecify)
DIVIS	ital or Attendrs after death al Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town	, State)	Rural Route Number,
_	To the Mospital within 24 hours a To the Funeral completely filled	Medical	one) 29b Signature and title of dertifier	ician: To the best of my knowler: On the basis of examination and manner stated. 74 Mwy ws.	on and/or inv	estigation, in my o	oinion, death occi	urred at the time, da	ate and place, and d	lue to the cause(s)
R			30. Name and address of person who cor		23a) (Type,				1	/ /
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2004	32. Registrar's Signatu		,				

		4	For State Ragistrar 1. Decedent's Name (First, Middle, Las	State of Ma	aryland				ealth a Death			g. No. 2 (04	0 3 6 (
	Physicia /Medic Examin	an al -		Johnson			4b. City,	Town, or	Location o		Month January	Day	Year 004 y of Deeth	4:37 P ^M
1	Funeral Director		Washington Adven 5. Social Security Number 6. S 577-32-5619 1	tist Kospi ex 7. Age	tal e (In yrs. last 78	birthday) Yrs.	If Under Months		a Par	24 Hrs. Min.	8. Date of Birth (Month, Day, May 16,	Monta 1925	9. Birthp	y blace (State or Foreigr sinia
	B Maryland B-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County BC		10c. City, T	own or Loc shingt		DC						l Od. Inside City Limits
	23e or 28	Funeral Director	100. Street and Number 1001 Bryant Stree	t, N.E.			10f. Zip	2001				USA		
9800	s 1 and 2 should be filed within 72 hours after death with the maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. If the marked other then "natural", or Iteme 23e or 28e-f ehow other traumatic event, the Medical Examinatings to notified at	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give A Year or Dates:	No	1	☐ Yes	2 ★ No	Specify:	gin? (Spec n, Puerto P	cify Yes or No- Rican, etc.)	Special Special	DIG	etc. ck
21215-0036	within 72 h ene. then "natu he Wedica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5		life. D	kind of wo OO NOT u	ork done d se retired	luring mos		99	16b. Kind of B	Govt.	dustry
ם	should be filed with nd Mental Hygiene. I marked other ther umatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Unknown			OOLID	ucci	Doce	18. Mothe		(First, Middle, M			
	alth and I		19a. Informant's Name/Relationship (Marion H. Johnson	· .	- 1						Route Number,		State, Zip. 2011	
Baltimore,	Page nent c ant: If ury or	1	20a. Method of Disposition 11 Burial 2 Cremation 3 C 1 Donation 5 Other (Specification 2). Signature of Funeral Service Incention	7)		e of Disposetery, crem	Mem.	Park		Jan.	9,2004 neral H		ver,	
	Physician Physician Physician Physician Medical		23a. Pand. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a CAR	DIOPU	710 Do not ente	6 Ker	nnedy de of dyin	Stre g, such as	eet,	N.W., Wa.	sh.,DC		Approximate Interval Between Onset and Death
68/6U,	re be executed /sician and eburial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as Due to (or as	a consequent	MIA nce of):								
P.O. BOX 0	the death certifical y the attending phy ched for use as th	Physiclan/Med	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	Ectopic p						ate of deliv	ery Day Year
	sign a be	ed by Ph	Part II. Other significant conditions	eontributing to death b	ut not resulti	ng in the ur	nderlying	cause giv	en in Part I			oacco use con os 2□No	ntribute to t	he cause of death? cably 4 Unknow
II Kecords,	The law ate has b page 2 sl	Completed by									24a. Was a autops perform 1 Tyes	y i	Were auto prior to co death? 1 Yes	ppsy findings available impletion of cause of
<u> </u>	Physicien: The I this certificate ha ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ⊠Inpatie	ent 2 EF	VOutpatien	t 3 D	OA Oth	90		(Check only on ne 5 ☐ Reside		her (Speci	(y)
Division of Vital	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be		y Year)	8b. Time of Injury	М		/at k? Yes 2□	No	28d. Describe ho			al Route Number,
N N	lospital or At hours after of uneral Directly ily filled in by		4 ☐ Ho <i>m</i> icide determined		c. (Specify)				ne, date a		City or Towr	, State)		
	he Hos in 24 hc he Fun pletely i	Medical	(Check only 2 Medical Exa-	miner: On the basis of and manner st	f examination	n and/or in	estigation	n, in <i>m</i> y o	pinion, dea	ath occurre	ed at the time, di	ate and place	, and due t	o the cause(s)
þ	To t Com	Σ	29b. Signature and title of certifier	MD				D4	652	19	-	JANU	ARY	2 2004
_	(6)	ate	30. Name and address of person who V CTOL CNY6 31. Date filed (Month, Day, Year)	JIAKA 73	DSA rar's Signatur	HARR	Print)	RPA	RKI	VAY	GREE	HBE	27 M	Africano 20

		1 - For State Registrar		nd / Department of Certificate of		lental Hygier	4004	0 ! 3	64
Physi /Med Exam	dical	1. Decedent's Name (First, Middle, Las	street and number)	4b. City, Town,	or Location of Death	JUN .	Day Year 04 4c. County of Death	3. Time of D	AM
Funera Directo		5. Social Security Number 6. So 578-54-0340 1 Usual Residence of Decedent		last birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Yes	9. Birthp Court 941 South	lace (State or F etry) Caroli	Foreign ina
ith the Marylan or 28e-1 ehow	Director	DC 10e. State 10b. County DC 10e. Street and Number 2.2.1.2 Duboing Diagram	Wa	shington, DC		10g.	Citizen of What Coun	0d. Inside City 1 ☐ Yes 2 stry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-1 ehow eny injury or other treumetic event, the Medical Eraciper must be redified at	by Funeral	3313 Duboise Pla 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates:		Hispanic Origin? (Spo ban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,		_
Maryland 21215-0036 id 2 should be filed within 72 hours aff the and Mental hygiene. It is marked other then "neturel", or treumetic event, the Medical Exercitivanian	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retir I.B.M. Superv	e during most of work ed)	ing	Kind of Business/Inc	lustry	
aryland should be file and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last) George Johnson S1 19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Stree	Leatha Mo			Code)	
altimore, Mimit. Pages 1 and 2 partment of Health a portent: If Item 27 is y injury or other tre		Rashida E1/Siste 20a. Method of Disposition 1X Burial 2 Cremation 3 Companies 4 Donation 5 Other (Specify	20b. Pl Co Removal from State	4900 Henderso lace of Disposition (Name of emetery, crematory or other place) Olivet Cemete	ace)	Date 20c.	, Maryland Location - City or To Shington, D	wn, State	}
Baltir permit. P Departme Importen eny injur		21. Signature of Funeral Service Licens	iée	22. Name and Addr 716 Kenne	edy St. N.	hnson & Je W. Washi	-	eral Ho	me
Fnysiciar /Medica Examine		23a. Part f. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (final disease or condition resulting in death)	a. CSG/A J Do to (or as a consequ	moune defice		or respiratory arrest,		Approximate Interval Betwee Onset and Dea	
ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any hading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	·					
.O. Box 63 the death certific y the attending p sched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregnand	y		23d. Date of deliver	y Day Yea	ar
Cords, P.O. Inveguires that the deben signed by the a		Part II. Other significant conditions co	ntributing to death but not resu	ilting in the underlying cause gr	ven in Part I.		use contribute to the		
The The ate h	e Completed by	6 AS WO (~ fo sh ~	uil bleed, ~	7	00 Plan of Park	24a. Was an autopsy performed?	death?	sy findings ava pletion of caus 200 No	ailable se of
Phys rthis	To B	examiner?		28b. Time of Injury Wo		ne 5 Residence 28d. Describe how inj			
or A strer after Direction by	i Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	building, etc. (Specify)			28f. Location (Street a City or Town, Sta	te)		,
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only one) 2 ☐ Medical Examination (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	ion and/or investigation, in my o	opinion, death occurre se number	ed at the time, date ar	ad place, and due to the same at the signed (Month, D	the cause(s)	
LO		30. Name and address of person who con Bahram Pishdad	ompleted cause of death (Item 9211 Stuart La	23a) (Type, Print)	1520 arvland 20		5-04		
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signation		ary rand 20	, 55			

		1- For State of Registrar	Maryland / Der	partment of F ertificate of		Reç	. No. 2 U U	4 01365
Dhysic	ion	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Dav Ye	3. Time of Death
Physic /Med		Delores Jean Jones				January	1 200	
Exam	iner	4a. Facility Name (If not institution, give street and numb	er)		r Location of Death		4c. County of D	
		Holy Cross Hospital 5. Social Security Number 6. Sex 7.	A /la la sa bisabila		lver Spri:			ntgomery
Funera		5. Social Security Number 6. Sex 7. 1 M 2 ☐ F	Age (In yrs. last birthda 62 Yrs.	Months Davs	Hours Min.	8. Date of Birth (Month, Day,) Nov. 24,	Year) 9.	Birthplace (State or Foreign Country)
Directo	4	Usual Residence of Decedent	02		<u> </u>	NOV. 24,	1741	Missouri
yland wow		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
Mar Mar	ģ	Maryland Prince George's	s	Cheve	er1y			1 ∑XYes 2 ☐ No
th the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
th will 23a	ai	5813 Carlyle St.			20785		Unite	ed States
r dea	Funerai	11. Marital Status 12. Was Deceder Armed Force	ent Ever in U.S. 13	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
S afte		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	African
Z 1 Z 15-UU36 d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at	Completed by	3 ☐ Year or Date 15. Decedent's Education		cedent's Usual Occup	nation	11	6b. Kind of Busine	American
10 72 in 72 in 72 in 72 in 10	jet	(Specify only highest grade completed)	(Gi	ve kind of work done . DO NOT use retired	during most of works	ing	ob. Kind of busine	333 madany
iene.	E O	Elementary/Secondary (0-12) College (1-4		cational H	Paraprofes	ssional	Gove	nment
	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		
Iryian should be nd Mental markad o matic eve	To B	Archie Tillman				Pearl R	obinson	
Maryland od 2 should be file th and Mental Hy to is marked othe traumatic event	2	19a. Informant's Name/Relationship (Type, Print)	1	ailing Address (Street				
re, Maryla s 1 and 2 should f Health and Men item 27 is marka		Elise B. Jones - Daughte		13 Carlyle		-		
Baltimore , permit. Pages 1 and Department of Heal Important: if item 3 any injury or other process.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1	110	position (Name of rematory or other place			oc. Location - City	or Town, State
Pages Pages Iment of I tant: If it		*4 ☐Donation 5 ☐ Other (Specify)	Harmony	Memorial I				ver, MD
Baltimor permit. Pages Department of I Important: if ite any injury or of		21. Signature of Funeral Service Licensee	1 111	22. Name and Addre		tewart Fu		
m		23a. Parn Enter the disease, or complications that cau			enning Rd.			20019 Approximate
ate be executed ate be executed This is a second of the burial-transit of the burial-t		resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events C.	as a consequence of): akemia as a consequence of): as a consequence of):	ry Arrest				Interval Between Onset and Death
the death certific by the attending placehold for use as 1	Physician/Med		n 2 🗍 Fetal death 3 It at time of death 5 In	3 □Ectopic pregnancy 5 □ Other (specify) □		23a Did taha	23d. Date of Month	delivery Day Year
dS, F ires tha signed I	à	Part II. Other significant conditions contributing to dea	an but not resulting in the	s underlying cause giv	eri iii Faiti.			Probably 4 Unknown
The law ate has be page 2 s	Completed					24a. Was an autopsy performs	24b. Were prior death	
Of VITAL Physician: 1 this certificat	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input	www.amesia	Oth		h (Check only one)		
Phys ral di	1: To	1 Yes 2 24No 1 27lnp 27. Manner of Death 28a. Date of (Month,		of 28c. Injur	er: 4 ☐ Nursing Ho y at	me 5 Residen 28d. Describe how		pecity)
On Ol Iding Phy Iff. : After thi	tion	1 ☑Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury		rk? Yes 2∐No			
UIVISION OT lal or Attending Phy s atter death. al Director: After this ed in by the tuneral d	Certification:	3 Suicide 6 Could not be 28e, Place of	Injury - At home, farm, , etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medicai (29a. Certifier (Check only one) 1 X Certifying Physician: To the base and manne	is of examination and/or	eath occurred at the tin investigation, in my o	me, date and place, opinion, death occurr	and due to the cau red at the time, date	se(s) and manne e and place, and	r as stated. due to the cause(s)
To the I within 2: To the I complet	Σ	29b. Signature and title of certifier		29c. Licens	~.	290	Date signed (M	onth, Day, Year)
(m)		(0,0		00	02 117		11110-	
(1)		30. Name and address of person who completed cause						
		Connie Le, M.D.	1500 Forest pistrar's Signature	Glen Rd.,	, Silver S	Spring, M	D 20910)
Regis	tate trar		LA Solymania	rette !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Delmer Woodrow Johns, Sr. January 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№** M 2 F 218 26 2513 29 1931 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Port Republic 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3633 Valley Road 20676 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married l ☑ Yes 2 ☐ No f Yes, Give Year or Dates: 1 ☐ Yes 2√2 No korea Specify samerican Indian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Building Custodian College (1-4or 5+) Calvert Co. GOV. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earnest L. Johns Virginia Duff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Johns - wife 1633 Valley Rd. Port Republic MD 20676 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 004 ervice Alexandria Virgini 1 ☐ Burial 2 ☐ Kemation 3 ☐ Removal from State Metropolitan Funeral 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral HomePA 4405 Broomes Is. Rd. Port RepublicMD 20676

Physician /Medical **Examiner**

burial-transit

Physician

/Medical

Examiner

Be Completed by Funeral Director

10a, State

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. In Medical Experiment 2002.

Physician/Medical Completed by Be Medical Certification:

Hospital or Attanding Physician: The law requires that the death certificate be executed

been signe should be o

certificate

After thi funeral

To the nospiration 24 hours after death.

To the Funeral Director: After the funeral bis the f

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused the death. Do not ly one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	usion		Onset and Death
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions,	D	Mi		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a consequence of):			
that initiated events resulting in death) Last	Due to (or as a consequence of):	1.7		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 NHNo 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
GI	Bleeding		1 □ Yes 2	□ No 3 □ Probably 4 □Unknow
quen	ia O		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Death	h (Check only one)	72.00 22.00
1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ∏Other (Specify)
27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigat		e of 28c. Injury at	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier (Check only one) Certifying I	Physician: To the best of my knowledge, de aminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as stated. I place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Dat	e signed (Month, Day, Year)
D. Sheh	ND	D 50290	1	-1-04

Prince

tredsich

MD

20678

State

Registrar

15+

DHIRPH

31. Date filed (Month, Day, Year)

41050

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah

JAN

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2003

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0445 am . Physician)anuar 2001 Lloyd William Kriner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Aug. 11, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2□ F Months 1928 Waynesboro, PA 75 Director 201-18-0452 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County f show r than "natural", or itema 23a or 28a-f shov Ite Medical Examiner must be notified at 1dTYYes 2 □ No Franklin Wavnesboro PA Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17268 USA 528 Fairview Avenue filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes & No Specify: SpecifyWhite ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine operator Machine Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fi Health and Mental H tem 27 is marked oth Be Edith G. Diffenderfer Lloyd A. Kriner ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Fairview Avenue Waynesboro PA 17268 if Item 27 is or other tra Gladys V. Kriner, Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Jan 18, 20 Waynesboro, PA Green Hill Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. eanette helmlu 50S Broad SI Wayenesboro, PA 17268 Approximate Interval Between Or set and Death 23a. Part1. Enter the disease, or complications that caused the Jeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be exeduted physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 × es 3 Probably 4 Unknown 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: atient 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 his 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1 Natural м 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funerel Director: A pupletely filled in by the fu death. 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 7

To the comple 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Prince 23a) TIVO State Registrar

		1 - For State Registrar	State of Maryl	land / Depa	artment of F rtificate of	lealth and Death		Reg. No.	200	4 0136	8
Physi /Med	ician dical	1. Decedent's Name (First, Middle, La BEDFORD LEE	KERNS				2. Date of De Month JAN	Day	0 20	3. Time of Death 2:22 A	
Exam	niner	4a. Facility Name (If not institution, giv			4b. City, Town, o		eath		County of De		
Funni		CIVISTA MEDICA 5. Social Security Number 6. S		yrs. last birthday)	LAPI		Irs. 8. Date of Birt	h	HARLE		ion
Funera Directo			№ 2 □ F	67 Yrs.	Months Days		MAY 3	193	6 VI	inthplece (State or Forei Country) RGINIA	gir
and *		Usuel Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	cation					10d Ipeido City Limi	•
ith the Marylan or 28a-f show	ō		RLES	. Only, Town of Ed		A PLATA	Δ			10d. Inside City Limi	
r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What (1	
th with	ai D	1 MAGNOLIA DRI	VE		2	20646		1	U.S.A	•	
72 hours after death with the Maryland 72 hours after death with the Maryland netural; or Items 23s or 28s-1 show dicel Examinet must be codified at	y Funerai I		12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No If Yes, Give	3 DM37	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)	}	14. Race - An Black, Wh Specify:		
72 hours natural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates: KO							WHITE	
드 환	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	tent's Usual Occup kind of work done DO NOT use retired	during most of v d)		Sou		SINDUSTRY MARYLAND AL CO.)
at Hyg other	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle,			AL CO.	
2 should be filed with and Mental Hygiene. Is marked other than	10 E	JAMES W.	KERNS			SUS	SIE SHOW	ERS			
s 1 and 2 should f Health and Mer Item 27 is marks other traumatic	8	19a. Informant's Name/Relationship (**				Rural Route Numbe				
of Health	1	20a. Method of Disposition		b. Place of Dispo	ROLLIN	1	DR • PO			• 20675	_
		1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cren	natory or other place		-16-04			AM, MARYLA	NT
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer		() ²² R	Name and Addres	ss of Facility FUNER	AL SERVI	CE,		AM, MAKILA	14
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the o	leath. Do not ent	er the mode of dyin	g, such as card	JAND 206 liac or respiratory are	46 rest,		Approximate Interval Between	-
Physician	1	Immediate Cause (Final disease or condition		IWOI	A.					Onset and Death	
/Medica Examine		resulting in death)	Due to (or as a con								
3 143	M	Sequentially list conditions if any leading to immediate	b. Due to (or as a con	C VE MA	T.A.					& DAN	
uted d ansit	Examiner	ficquentially list ronditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		30,100 31/.							
a exec an an irial-tr		resulting in death) Last	Due to (or as a con	sequence of):							
ficate be executed physician and s the burial-transit	edical		d								
		IF FEMALE:	23c. If yes, outcome of pre	ananov.				7			
The law requires that the death certification is the law requires that the death certification is a second of the strength of the strength of the second for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	Ectopic pregnancy Other (specify)			23	3d. Date of de Month	olivery Day Year	
that the de ned by the	hysi	9 Unknown	9□ Unknown		(-)						
w requires that been signed be should be det	by P	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco us	e contribute t	o the cause of death?	
requii	eted					-,	- 1 2	es 2 🗆	lNo 3□P	robably 4 Unknow	1
e law has b	Completed						24a. Was a autops	SV	prior to	utopsy findings available completion of cause of	8
	င္ပ	25. Was case referred to medical					1 ☐ Yes	215/10	death? 1 ☐ Ye	s 2 No	
Physician: r this certific ral director.	o Be	examiner?	Hospital:	2 🗀 ER/Outpatien	3□ DOA Othe		eath <i>(Check only or</i> Home 5 🗆 Reside		Coher (Co		-
ding Phys h. After this funeral dir	n.	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injury Work		28d. Describe he			ecity)	+
Attending r death. ector: After oy the fune	atio	1) Naturel 5 Pending investigation		, injury		Yes 2□No					
after d Direct	ertification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · A building, etc. (Spe	at home, farm, streecify)	et, factory, office		28f. Location (Si City or Town	reet and n, State)	Number or R	ural Route Number,	
To the Hospitel or Attending Ph Mithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the timestigation, in my op	e, date and pla pinion, death oc	ce, and due to the courred at the time, d	ause(s) a ate and p	nd manner a	s stated. e to the cause(s)	
To the To the comple	Me	29b. Signature and title of certifier	11/1		29c. License	number	2	9d. Date	signed (Moh	th, Dey, Year)	_
(11)		1/2/m/	to all	- m) _{D-20}	629		1/	10/	04	
W		30. Name and addre s of lerso who d	completed cause of death (Item 23a) (Type, F				31			
		GEORGE H.WATHE	N MD 11345	PEMBRO	OKE SQ.	SUITE	103 WAL	DORF	F, MD	20603	
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	nout i						

			1 - For State Registrar	Si	tate of M	larylan		artment of tificate of				eg. No.	04	01369
	Physici /Medio		1. Decedent's Neme (First, Mid ROBERT K. KET	TERER							2. Date of Dea Month JANUARY	1, 200		3. Time of Death 9:30 P ^M
	Examir Funeral	er	4a. Fecility Name (If not institut. HEARTLAND HOU 5. Social Security Number	6. Sex	7. A	Age (In yrs. i	ast birthday)	GRASON If Under 1 Yea Months Days	VILLE		8. Date of Birth (Month, Day	4c. County QUEE	N ANN	
	Director		164-01-2910 Usual Residence of Decedent 10a. State 10b. Coun	1 X M	2 F	85	Yrs. y, Town or Lo		Thouas .		JUNE 15	, 1918	PEN	NSYLVANTA 10d. Inside City Limits
	with the Maryl a or 28a-f sho Lbe nutified a	Director	MD ANNE	ARUND		SEV	ERNA P.	10f. Zip Code 21146	-		1	0g. Citizen of	What Cou	1 ☐ Yes 2 No
9036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturet" or items 23a or 28a-f show event, the Mudical Exa virwer mast be nutified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mi 3 🏿 Widowed 4 ☐ Divorce	irried 1	Vas Deceden Armed Forces VYes 2 [Yes, Give Year or Dates	?]No		Was Decedent of f Yes, specify Cu			ecity Yes or No- Rican, etc.)	Bla	ce - Ameri ck, White,	
21215-0036	within 72 ho Bne. than *netu	Completed by	15. Deced (Specify only high Elementary/Secondary (0-12		n npleted) College (1-4o	r 5+)	(Give life. L	lent's Usual Occi kind of work don OO NOT use retir	e during mos	st of work	ing	16b. Kind of B		ndustry
Maryland 2	be filed ntal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle THEODORE KETT		<u> </u>		THINK	BIINO			e (First, Middle, I	Maiden Sumar		
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic QDCB.		19a. Informant's Name/Relatio WILLIS GERHAR' 20a. Method of Disposition 1	JR./ 3 □Remo	STEPSO	20b. P	214 lace of Dispo emetery, cren SAPEAK	LONG POJ sition (Name of natory or other pl E CREMA)	ace) CORY CORY	., Si	/2004	LLE, MI 20c. Location STEVENS	City or To	666 own, State
/60,	ate be executed /Medical Examiner transit pe burial-transit	ical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (or a	s a consequ	Bockwarence of):	al P	٧٠٠٠	~ `~				Approximate Interval Between Onset and Death
O. BOX 68	at the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		yes, outcom	2 Fetel	death 3	Ectopic pregnan Other (specify)	су		30.		te of delive	ery Day Year
cords, P	v requires that been signed should be de	by	Part II. Other significant condi	tions contribu	iting to death	but not resu	ulting in the un	nderlying cause g	iven in Part I			s 2 No	3 Prot	he cause of death?
Vital Records,		e Completed	25. Was case referred to media	al					26. Place	of Death	autops	ned?	prior to co death? 1 Yes	psy findings available mpletion of cause of
ō	Phys this rat di	ation: To B	_ (_ / 100 ido iii	ing tigation	tal: 1 Inpat 3a. Date of In (Month, D	iury	ER/Outpatien 28b. Time of Injury	28c. Inju		1	me 5 - Reside 28d. Describe ho			soft sisted him.
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	l Certification;	4 Homicide	mined 2	building, e	etc."(Specify	·)	et, factory, office			28f. Location (St. City or Town	. State)		
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	Medical	29a. Certifier (Check only one) 29b. Signature and title of certification (Check only one)	f Examinar:	On the basis and manner s	of examinat stated.	ion and/or inv	restigation, in my 29c. Licer	opinion, dea	th occurr		ate and place, and Date signe	and due to	Day, Year)
			30. Name and address of person		eted cause of	death (Item	23a) (Type, I	Print)	1320	36	has hir.	1/2 MA 2	(100)	7
	Sta Registr		31. Date filed (Month, Day, Yes	1062	32. Regis	far's Signat	ture	Sperk			and him.		7 4 (9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 100.4 Month **Physician** ea SSa January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mallaro Dtevensul 22 Huenue veen Anne's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🕱 F 9 Yrs. 215-41-1280 Director 19, 1994 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at MD QUEEN ANNE'S STEVENSVILLE 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 122 MALLARD DRIVE 21666 USA by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT **EDUCATION** 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) æ is marked of DONALD GERARD KLINE JULIANNE JACOBSON ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other tra DONALD GERARD KLINE/FATHER 122 MALLARD DR., STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State JAN. 8, 1 X Burial 2 □ Cremation 3 □ Removal from State BROAD CREEK CEMETERY STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Lentre 106 SHAMROCK RD., CHESTER, MD 11MW 23a. Part T. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical cate has been signed by the attending physi , page 2 should be detached for use as the l that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yas 2 🗷 No 3 ☐ Probably 4 ☐ Unknown ģ Be Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of death? 1 🗆 Yes certificate 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this e funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours effer death. To the Funerel Director: Af completely filled in by the fu efter death. 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

29c. License number

Baltimore

Room

State Registrar (Check only one)

29b. Signature and title of certifier

1650 Or leagns

JAN 0

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** John James Lilly 2:40 A January 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Director 79 207-18-1789 March 23, 1924 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show s 23a or 28a-f show 1 ☑ Yes 2 ☐ No Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a Funeral 9701 Veirs Drive 20850 USA death 1 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes Give 4 0 4 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Madical Examiner: Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943-46 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th Cabinet Maker Woodworker permit. Pages 1 and 2 should be fite.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Lilly Jeanette Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9539 Veirs Drive, Rockville, MD 20850 Mildred Lilly/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 1/5/2004 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hysong Company, Inc. W. W. 6510 16th Street, NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Day Acute Myocardic Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner Tany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed signed by the attending physicien and the detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1XXnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title/of certifie 1)6055 January 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shue, MD 9901 Medical Center Drive, Rockville, MD Leo L. 20850 31. Date filed Mon 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla		ment of Hea		ental Hygie	2001	. 01372
			1. Decedent's Name (First, Middle, Last	')				2. Date of Death		3. Time of Death
	Physic		NANCY		_	EWIS		Januan	Day Year	0630 AM
* * * * * * * * * * * * * * * * * * * *	/Medi Examii Funeral Director		4a Facility Name (If not institution, give 1.5. Social Security Number 6. Se 230-22-7358 1.5. Usual Residence of Decedent	apkins Hos	OI fal /	Under 1 Year If	Cation of Death Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You April 10	4c. County of Dea	
	land ow		10a. State 10b. County	10c. C	ity, Town or Locati	on				10d. Inside City Limits
	the Marylar 28a-f ehow notified at	ţō	Md	9	Saltim	no ca				1 Yes 2 □ No
	with the Maryland a or 28a-f show the notified at	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	23a c	a D	2011 Saint Cla	hic hane		21213	3		1.5.A	,
	ter death Items 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	Decedent of Hispar is, specify Cuban, M	nic Origin? (Spi	ecify Yes or No-	14 Race - Ame Black, Whit	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1		pecify:		Specify:	i i
5-0036	72 hours after "natural", or its	pe pe	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a Dandani				1 6	ack
215	n na	Completed	(Specify only highest grad	le completed)	(Give kind	's Usual Occupation I of work done durin NOT use retired)	n g most of work	ing 16t	o. Kind of Business/	Industry
212	filed within Hygiene. Ither then *	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Do	mestic	-	ρ	RIVATO	c
	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, It a Ma	BeC	17. Father's Name (First, Middle, Last)					(First, Middle, Mai		
ylai	Ments Ments arked	To	George Olive	_			J050	ohine Il Route Number, Ci	Oliver	-
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Itam 27 Ie marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		19a. Informant's ame/Relationship (Ty	rpe, Print)	19b. Mailing A	ddress (Street and I	Number or Rura	il Route Number, Ci	ity or Town, State, 2	(ip Code)
- 105	other tr		Nancy Sue	(Dauster	746 n Place of Dispositio cemetery, cremato	Melville 1	Ave., I	Daltimo	re Md.	21218 Town, Stete
altimore	nt of the state of		20a. Method of Disobsition () 155 Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, cremato	n (Name of ry or other place)				
tir	permit. Page Department o Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify)	01	iver fami	ly Cometer,	11-7	-04 C	rewe,	Va unesal Service
Ba	permit. Departr Imports eny inj		21. Signature of Funeral Service Licente	Dhase	41L	A Market	Facility Ca	1 4.295	le Vc &	uneal Device
,	Take P		23a. Parti. Enter the disease, or complishock, or heart failure. List only or	ications that caused the dea	th. Do not enter th	e mode of dying, su	ich as cardiac d	r respiratory arrest,	le vc o	Approximate
	Physician		Immediate Cause (Final disease or condition	.0				The second of		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		NYOCIM	DIPL	Anton	CTION	Hours
	Examiner		Sequentially list conditions.	1-44	phio	NSIM				VICAMS
	sit sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons						. !
	be executed iician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a consec	(PANS (5-"T	(2)				Ytome's
8760,	cate be executed ohysician and the burial-transit				1001100 01).					
687	tificate ig phys as the	edical								
Вох	attendir for use	Physician/M	in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of controls.	il death 3 □Ecto	opic pregnancy			23d. Date of deli	very Day Year
o.	at the de by the tached	ysk	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9 Unknown	300	er (specify)				
٥.	s that ned b e deta	by Pi	Part II. Other significant conditions cor	stributing to death but not res	sulting in the under	ying cause given in	Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	w requires been sign should be							1 🗆 Yes	2 No 3 Pro	bably 4 Munknown
900	awre	Completed						24a. Was an	24b. Were aut	opsy findings available
ř		ĕ						autopsy performed 1 ☐ Yes 2 🔀	? death?	ompletion of cause of 2 No
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?			26.	Place of Death	(Check only one)	140 1 10 163	2 140
o S	Physician: this certificanal director,	2	1 ☐ Yes 2√2 No		ER/Outpatient 3	□ DOA Other: 4	☐ Nursing Hon	ne 5 Residence	6 ☐ Other (Spec	ify)
	ing After une	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	2	8d. Describe how in	njury occurred	
Division	ne sat	cat	2 Accident investigation 3 Suicide 6 Could not be	00 51 111		A 1 ☐ Yes				
<u>></u>	or Attendater death after death Director: /	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	ome, tarm, street, t	actory, office	2	8f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
_	Hospite 4 hours Funeral tely fille	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occution and/or investig	urred at the time, da gation, in my opinion	ate and place, a	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and maining stated.		29c. License num			Date signed (Month)	
)	- 3 F (by Auc. d.	~ MD		000	354		PHURRY	
7			30. Name and address of person who co		n 23a) (Type, Print	1		(00)		SUPE ST.
-				NG MO	JOHNS 1	topking i	125/12-		unise;	
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Signa	_					, , ,
1	Registr	ar	JAN 0 6 2004	Kent K	houle	•				

ORIGINAL

		For 1 = State Registrar	State	of Marylar		artment o			Mental Hyo	giene Reg. No. 200	4 01373
		1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea		3. Time of Death
Physici /Medi		Helen Brina	Lerner						January		1:15 p M
Examir		4a. Facility Name (If not institution				4b. City, Tov				4c. County of (Death
		Hebrew Home o					Rockv			Montg	
Funeral		5. Social Security Number 579-07-3685	6. Sex 1 □ M 2 🛣 F		. last birthday) Yrs.	If Under 1 Y Months D	ays Hou	der 24 Hrs. S Min.	8. Date of Birt	h y, Year) 9.	Birthplace (State or Foreign Country)
Director	,	Usual Residence of Decedent		88	113.				June 10	, 1915 W	ashington, DC
land		10a. State 10b. Count	,	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Mary 1 sh	ē	Maryland Monts	omery	İ	Rocks	ville					1 X Yes 2 □ No
1 the	Directo	10e. Street and Number	,02_)		ROCK	10f. Zip Co	de			10g. Citizen of Wha	t Country?
3a o 81 Le	Ö	6121 Montrose	Road			2	20852			U.S.A.	
death	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. \	Was Decedent	of Hispanic	Origin? (Sp	pecify Yes or No- Rican, etc.)		American Indian,
after or Ita		1 Never Married 2 Ma	ried 1 □ Yes	2 ÎXÎ No		ires, specily 1□ Yes 2⊡			nican, etc.)		White, etc.
ours Frait,	d by	3 XWidowed 4 ☐ Divorce	If Yes, G Year or (Dates:		103 20	-140 <i>Ope</i> 0	y.		Specify:	White
72 h	Completed	15. Decede (Specify only high	nt's Education est grade completed,		16a. Deced (Give	dent's Usual O kind of work of DO NOT use r	ccupation one during n	nost of wor	king	16b. Kind of Busin	ess/Industry
Mithin Mithin	m	Elementary/Secondary (0-12)	Collage (1-4or 5+)						Maria	
iled v tygie thart		17. Father's Name (First, Middle	(ast)		00	oncert			ne (First Middle	Music Maiden Surmame)	
all be full be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did be the did by the did be the did by the did	Be	Louis Stein						Clara		Maiden Sunama)	
d Me d Me mark matic	2	19a. Informant's Name/Relation			19h Mailir	na Address /Si				or, City or Town, Sta	te Zin Code)
MC d 2 s than than traus		Carolyn Bernac		hter	1	-				ge Park,	
Heal Heal Heal Sther	1	20a. Method of Disposition	2008		Place of Dispo				Date	20c. Location - City	
ages nt of t: # it		1 ☐ Burial 2 🖽 Cremation		State I	cemetery, crem ropolita			01/0	4/2004		ria, Virginia
paritificity, Mary fattice 2 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other traumatic event, the Madical Exeminer must be notified at ance.		' 4 □ Donation 5 □ Other (1.20			-				
Depariment of the control of the con		> alpsh	W. I	Will	en 47	739 Bal	timore	Gase Ave	on's Fun nue, Hya	eral Home	e, P.A. MD 20781
		23a. Part1. Enter the disease, of shock, or heart failure. List	r complications that t only one cause on	caused the dea each lin	th. Do not ent	er the mode of	dying, such	as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a	570	LOKE						Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):						
LAdminer	_	Sequentially list conditions,	b								
ed	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	2 Due to	or as a conse	quence on:						
xecut and al-trar	Examin	that initiated events resulting in death) Last	c Due to	(or as a conse	quence of):		-				
cate be executed cate be executed obysician and the burial-transit	dicai E										
ficate g phys	edic		u.								
n certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	tcome of pregr	nancy	Ten				23d. Date of	fdelivery
death death death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 <u>□</u> Preg	birth 2 ☐ Fet nant at time of]Ectopic pregn] Other <i>(specit</i>				Month	Day Year
by the	hys	9 🗆 Unknown	9□ Unkr	nown						Executions	
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	by P	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying caus	e given in Pa	urt I.	23e. Did to		te to the cause of death?
w require been sis									1 🗆 Y	′es 2.⊡•No 3.[Probably 4 Unknown
as be	Completed								24a. Was autop	an 24b. Wer	e autopsy findings available to completion of cause of
vician: The lavicetrificate has	Ö								perfor 1 ☐ Yes	rmed? 🖊 💢 deat	h? Yes 2∐ No
sian:	Be (25. Was case referred to medic examiner?	al				26. PI	ace of Dea	th (Check only o	ne)	
hysic his ca	P	1 ☐ Yes 2 💢 No			ER/Outpatien		the second second	Nursing H		lence 6 Other (Specify)
ding Ph h. After th funeral	 	27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date ing (Moi	of Injury oth, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe h	low injury occurred	
tandi eath. for: A	cati		tigation			М	1 ☐ Yes 2	□No			
or Att	Certification:		mined 286. Plac	e of Injury - At I ling, etc. (Spec	home, farm, str ify)	eet, factory, of	fice		28f. Location (S City or Tow		r Rural Route Number,
urs a			1								
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarel Diractor: After this certificate ha completely filled in by the funeral director, page	edical		ing Physician: To th I Examiner: On the l and mai								
Fo th within Fo th	Me	29b. Signatur and title of certific	er a 17		220	2ic. Li	cense numb	er ,	:	29d. Date signed (M	1
		1 / freex	U/ Gun	ter MI		D	494	11		VAC	1 3 2004
(5)		30. Name and addre	who completed cau	se of death (Ite	m 23a) (Type,	Print)	In.		/	2.0	1 3 2004 KVILLE MD
		GILEGORY	4-0	MPT	ONN	106	121	Mon	trose 1.	29 1200	KVIILE MD
	ate	31. Date filed (Month, Day, Yea		Registrar's Sign	nature	<i>d</i> .					
Regist	rar	JAN 072	004	W S.	ANDA						

			1 - For Stete Registrar Amend Item#26p	State of Man					and M		giene Reg. No. 2 (004	0.13	71	
	D1		1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time of Deat	h	
}	Physici /Medio Examir	cal	Erline Katie Lawso			4b. City,	Town, or	Location o	of Death	Januar		04	23:28	М	
			Union Hospital of				kton 1 Year	If Under 2	24 Hrs	O. Data of Bird	Cec				
	Funeral Director		5. Social Security Number 6. Sex 257-54-3643	M 2⊠F	n yrs. last birthday) 65 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day July	, Year) B, 1938		place (State or For ntry) corgia	eign	
	yland how		10a. State 10b. County	10	Oc. City, Town or Lo	cation						1	IOd. Inside City Lin	_	
	he Ma	Director	Maryland Cecil		Elkton	124 7							1 □ Yes 2 🔁	No.	
	with t	قَ	10e. Street and Number			10f. Zip		2.1			10g. Citizen of		,		
	death	Funeral	1 Connley Court	2. Was Decedent Eve	er in U.S. 13.	Was Dece	2192 dent of Hi		gin? (Spe	cify Yes or No- Rican, etc.)	United 14. Rad		ces can Indian.		
920	be filed within 72 hours after death with the Maryland hat Hygiene. ud other than "natural", or items 23a or 28e-f show avent, the Medical Examinar must be notified at		1 ☐ Never Married 2 ⅔ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		lf Yes, spe 1 ☐ Yes		Specify:	, Puerto I	Rićan, etc.)	Bla Specif	ck, White, y: W	etc. nite		
21215-0036	72 ho natur	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	kind of wo	rk done d	uring most	of working	ng	16b. Kind of B	usiness/In	dustry		
121	filed within Hygiene. other than " ent, the Me	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	<i>DO NOT u</i> Home:				Own home					
d 2	e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)						r's Name	Name (First, Middle, Maiden Surname)					
ylaı	2 should be and Mental I is marked o	2	James Thompson							Renfro					
Maryland	C1 (0 == 60	1 0	19a. Informant's Name/Relationship (Typ		1					Route Numbe	-		Code)		
	thealth tem 27 other tr		Bobby Jack Lawson/ 20a. Method of Disposition		20b. Place of Dispo	sition (Nar	ne of		D	n, Mary	20c. Location		own, State		
9 E	Pages nent of int: If it		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crer Mayerdale	-			anua: 2004	ry 9,	Newark	ne î	aware		
Baltimore,	permit. Pages 1 as Department of Hea Importent: if item any injury or othe		21. Signature of Fuperal Se vice License		22	. Name ar	nd Addres	s of Facility	Cr	ouch Fu	neral H	ome	yland 21	۵0	
8760,	Examine Medical Examine Principle Stock Associated Principle Principle Stock Principle Principle Principle Principle Principle Pr	al Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	onsequence of):			- C	eardiac o	Tespiratory and	est.		Approximate Interval Between Onset and Death		
P.O. Box 687	death certifica e attending ph id for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pr Other (sp						te of delive	ory Day Year		
	es tha igned be de	þ	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying c	ause give	n in Part I.		23e. Did to			e cause of death? ably 4 ⊟Unkno		
Vital Records,	law requir ias been s s 2 should	Completed	COPD.							24a. Was a autops	sv l i	prior to con	psy findings availa	ble of	
<u>=</u>	i: The licate h			lesterol						perform 1 ☐ Yes		death?	2□ No		
Ζij	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 X ER/Outpatien	t 3□ DC	Othe	_		(Check only of te 5 ☐ Reside	5	or (Casait			
οt		-	27. Magner of Death	28a. Date of Injury (Month, Day Ye			Bc. Injury Work			8d. Describe h			"	_	
sion	Attending I r death. ector: After by the funer	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		,,	М		es 2□N	10						
Division	tal or Attencrs after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)	eet, factory	r, office		2	8f. Location (Si City or Town	reet and Numb n, State)	er or Rura	i Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the funeral or the funeral Direction of the funeral filled in the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of m er: On the basis of exa and manner stated	amination and/or inv	occurred restigation	at the time in my op	e, date and inion, death	place, a h occurre	nd due to the c d at the time, d	ause(s) and ma ate and place,	nner as st and due to	ated. the cause(s)		
	To the To the Comp	Ž	29b. Signature and title of certifier			290	. License		=/	2	9d. Date signed	٠.	Day, Year)		
	,		Morango	100		T	706	607	J6		1/310	4			
	6		30. Name and address of parson who con	and the same of th	h (Item 23a) (Type,	-									
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's										·	
	Registr	ar	JAN 0 6 2004	Po alling o	. H. So	alle									

		ŕ	1 - For State Registrar		arylan		artment of rtificate of			Reg. No.	01375
	Physici	an	1. Decedent's Name (First, Middle						2. Date of De Month	Day Year	3. Time of Death
н	/Medic	al	Mabel Elizabeth 4a. Facility Name (If not institution,				4b. City, Town,	or Location	January	4, 2004 4c. County of Death	4:00 AM M
П	Examin	er				442442			or Death		
	Funeral		Laurelwood Nurs 5. Social Security Number	6. Sex 7. Ag		<u>1 CaC1O</u> last birthday)	If Under 1 Yea	r If Under	24 Hrs. 8. Date of Bi		place (State or Foreign
	Director		152-30-1270	1□M 2X F	90	Yrs.	Months Days	Hours		er 25, 1913	New Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl 1 sho	ē	MD Cec	1		TO 1 1-4					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	<u> </u>		Elkt	10f. Zip Code			10g. Citizen of What Cou	ntry?
	15 with with 123 of 123	aiD	42 Elk Chase Di	ive			219	921		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica	igin? (Specify Yes or No n, Puerto Rican, etc.)	o- 14. Race - Ameri Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates:	No.		1⊡Yes 2 X DNo	Specify.		Specify: Whi	te
5-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28a-f show ta Madical Examirer huat be natilised at	ed	15. Decedent	s Education		16a. Dece	dent's Usual Occi	upation		16b. Kind of Business/Ir	dustry
215	hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give	kind of work don DO NOT use retir	e during mos ed)	st of working		
2121	filed wit Hygiene other the	S	12	4		Regis	tered Nu			Medica1	
	be fill	Be	17. Father's Name (First, Middle, L A. Addison Seve						er's Name (First, Middle	, Maiden Sumame)	
Maryland	should be filed within 72 hours after death with the Marylan Id Mental Hygiene. marked other than "natural", or Items 23e or 28e-f show marked other than "natural", or Items 23e or 28e-f show matic event, it e Medical Examinar over the malikal at	ဥ	19a. Informant's Name/Relationsh			10h Mailir	a Address /Stree	-	h Porter	er, City or Town, State, Zij	Code)
Ma	ith an		Bonny V. Vanove			0			kton, MD 21		, code,
ē,	s 1 ar f Hea item 3		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other pl		Date Date	20c. Location - City or T	own, State
Ë	Page ent of nt: If i		1 ☐ Burial 2 XCremation 1 ☐ Donation 5 ☐ Other (Sp		RA	Ferris	& Co.,	Inc.	01/05/04	West Cheste	er, PA
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic a <u>once</u> .		21. Signature of Fuperal Service	Willown		A	Name and Add	Gee		259 E. Main Elkton, MD 2	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deat		uneral F er the mode of dy			· ·	Approximate Interval Between
Z.	Pnysician		Immediate Cause (Final disease or condition	150	hen	10 B	one				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):					
1	Examine:	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consen	nence of).					
Т	ited Insit	Examiner	Cause (Disease or injury	Fail	VM	TE	HOUT				
Ć.	execu n and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):					
8760,	Attending Physicien: The law requires that the death certificate be executed r death. sctor: After this certificate has been signed by the attending physician and better this certificate has been signed by the attending physician and by the funeral director, page 2 should be delached for use as the burial-transit	icai		d							
89	ertifica ing ph e as th	Med	IF FEMALE:	T							
Box 6	ires that the death certific signed by the attending p d be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 1/2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic pregnan	су		23d. Date of deliv Month	ery Day Year
<u>о</u> .	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	t time or a	eath 5	Other (specify)				
	s that hed by deta	by Ph	Part II. Other significant condition	ns contributing to death t	out not res	ulting in the u	nderlying cause g	iven in Part	. 23e. Did	tobacco use contribute to t	he cause of death?
Records,	w requires been sig should be								1	Yes 2 ☐ No 3 ☐ Proi	pably 4 Unknown
000	e law re has bee je 2 sho	plet	(1)						24a. Was	an 24b. Were auto	psy findings available mpletion of cause of
<u> </u>	The I	Completed								ormed? death?	No No
/ita	Physicien: The l this certificate ha al director, page	Be (25. Was case referred to medical examiner?,	111					e of Death (Check only	one)	
o	Physi this c	၉	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inji		ER/Outpatier 28b. Time of	IL 3 LI DOA			idence 6 Other (Special how injury occurred	(y)
CO	ding h. After funer	tion	1 Natural 5 Fendin	(Month, Da	Year)	Injury	W	ork? ⊒Yes 2. □		now injury occurred	
Division of Vital	Attend r death sctor: /	fica	3 Suicide 6 Could r	ot be 28e. Place of In	ury - At h	ome, farm, str	eet, factory, office		28f. Location (Street and Number or Run	al Route Number,
á	s after of Dire	Certification;	4 Homicide	building, e	іс. (Бресії	у)			City or To	wn, State)	
	To the Hospital or Attending F within 24 hours after death. To the Funeret Director: Atter completely filled in by the funer	Medical (of examina					cause(s) and manner as s date and place, and due to	
	To ti Vithii To ti comp	ž	29b. Signature and title of certifier					nse number		29d. Date signed (Month,	4
	1		Har	4			D540	75		05 Jan 0	(
	3		30. Name and address of person	who completed cause of	death (Iten	23a) (Type,	Print) (HUZCHA	ngu?	on Ver	w Castle Dr	= 19720
	Sta Registi		31. Date filed (Month, Day) Year) JAN 0 6 2004	32. Regist	rar's Signa	Ana M.	,				
	-			- Carried	-	10 10 10 10 10 10 10 10 10 10 10 10 10 1					

Physic		1. Decedent's Name (First, Middle, Li	ast)						2. Date of Da	ath 1/	1/2004	3. Time of Death
40.0	. 19	RUTH COURTNEY L							Month	Day	2004	r M
/Medi Exami		4a. Fecility Name (If not institution, gi	ive street and number)		4b. City	, Town, or	Location of	ol Death	JANUAI	-	County of D	17:10P.
Exam	iiei M	JOHNS HOPKINS HOS			BAT	TIMO	DE.					
Funeral Director		Social Security Number 6.		(In yrs. last birthd 89 Yrs	Months	r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	h y, Year) , 19		Birthplace (State or Foreign Country) ARYLAND
ъ.		Usual Residence of Decedent		10a City Town o	Location							10d. Inside City Limits
aryla shov	_	10a. State 10b. County	CTT 4.16	10c. City, Town or								1 Yes 2 No
he M	Director	VA ROCKIN 10e. Street and Number	GHAM	FULKS R		p Code	-			10a Citiz	en of What	
with a or	٦		OAD			2830				USA		,
Jeath	Funerai	13010 3RD HILL R	12. Was Decedent B	ver in U.S.	3. Was Dece	dent of Hi	ispanic Orig	gin? (Spe	ecity Yes or No	merican Indian,		
be filed within 72 hours after death with the Maryland ital Hygiene. Indoorher then "natural", or flems 23a or 28a-f show event, the Michel Examiner must be multipled at		1 Never Married 2 Married	Armed Forces? 1 Yes 2 X	lo	II Yes, sp		n, Mexican Specify:	, Puerto	Rican, etc.)		Black, W	
ours iral;	d by	3 XWidowed 4 □ Divorced	Year or Dates:		1 1 103	200110	эрвину.				Specify:	WHITE
72 h natu	Completed	15. Decedent's t (Specify only highest g) (G	cedent's Usi	ork done a	lurina mosi	t of work	ing	16b. Kin	d of Busine	ss/Industry
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a Hosp 24 hou s Fune etely fii	edical	29a. Certifier 1 Certifying F (Check only 2 Medicel Ex-	Physician: To the best of eminer: On the basis of and manner sta	examination and/o	eath occurre r investigatio	at the tim n, in my or	ne, date an pinion, dea	d place, th occurr	and due to the red at the time,	cause(s) a date and	and manner place, and d	as stated. ue to the cause(s)
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E > E 0		I him hi.	mid			0.C	.M.E.		J	ANUA	RY 2,2	2004
		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Ty								
		L (IVG LI. N 31. Date filed (Month, Day, Yaar)	()		111 I	enn :	Stree	t, E	Baltimor	e, M	arylaı	nd 21201

NEST S.	LYĭ	NN For State Registrar	State of Mary	land / Depa		ealth and M	ental Hygi		01377
Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, I Ernest 4a. Facility Name (If not institution, g MEMORIAL HOSPIT	Samu	iel	Lynn 4b. City, Town, or L		2. Date of Death Month		
Funeral Director		5. Social Security Number 6 217-36-6839 Usual Residence of Decedent	Sex 7. Age (In 7. 5	yrs. last birthday) Yrs.			8. Date of Birth (Month, Day,) 03/09/19		place (State or Foreign ntry) nington, DC
Definitione, Maryiaria 4 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23e or 28e-f show any injury or other treumatic event. If a Medical Examinar must be notified at once.	To Be Completed by Funeral Director	10a. State MD Alle 10e. Street and Number 16818 Broadwate 11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of Specify only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest o	r Lane 12. Was Decedent Ever Armed Forces? 1	16a. Dece (Give life. U W SON 19b. Mailin P. O Ob. Place of Dispo cemetery, cren Cumberla	burg 10f. Zip Code 21 Was Decedent of Hist f Yes, specify Cuban, 1 — Yes 2 No dent's Usual Occupation of work done due to NOT use retired) rapper 1 1	Specify: on ring most of working 8. Mother's Name Gladys d Number or Rural Frostbu ory 01/03 of Facility Sow	(First, Middle, Ma (Lyn Route Number, C rg, MD ate 20 / 2004 C ers Fune	g. Citizen of What Cou USA 14. Race - Amen Black, White Specify: Whi Sb. Kind of Business/Ir Bakery aiden Sumame) 11) City or Town, State, Zig 21532 Dc. Location - City or Town Sumberland,	can Indian, etc. te idustry Anderson o Code) own, State MD
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vrequires that the death	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	23c. If yes, outcome of prince of pr	Fetal death 3 of death 5	Ectopic pregnancy Other (specify)	in Part I.		23d. Date of deliver Month cco use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to cont	Day Year
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To the Hosy within 24 hosy to the Fune To the Fune completely fi	Medical	29b. Signature and title of certifier 30. Name and address of person who HEDDOREM 31. Date filed (Month, Day, Year)	32. Registrar's S	(Item 23a) (Type, F	29c. License n O.C.M Print) D. Street,	umber	d at the time, date	Date signed (Month, JAN . 3 , 2	the cause(s) Day, Year)
Registro	ar	JAN 1	2 2004) Elecus	as St.	Gosto"				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle | ast Day Month Yeer **Physician** Iola M. Martin 2004 8:45am January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Forestville
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Prince George The Millennium of Forestville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F Months 65 19, 1938 North Carolina Director 241-56-7684 Jan. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 le marked other then "netural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at D.C. 1 ☑ Yes 2 ☐ No Washington Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2330 Good Hope Rd. SE. #616 20020 United STates death 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Educator other then Elementary/Secondary (0-12) College (1-4or 5+) Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be item 27 le marked o Unknown Catherine Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bisanabi/Friend 7007 Selena Place, Forestville, MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ō = 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Importent; If any injury of any injury of * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. Jan. 6, 2004 Suitland, MD. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 22 Name and Address of Facility 21. Signature of Funeral Service Licenses 20747 23a. Part. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Cancer 8 months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No o 9 Unknown 9 Unknown ۾ Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Types 2 1 No 3 Probably 4 TUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2X No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A 2 🗌 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only within 2 one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 10060552 30 Name and ac use of death (Item 23a) (Type, Print) ess of person who ca 19703 Executive Park Circle, Germantown, MD. 20874 Steven Fong, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2004 Registrar

	•	For State Registrar	State of Maryla	nd / Dep	artmer		•		2001	. 01379
Physicia /Medic Examin	al .	Decedent's Name (First, Middle, Last LEVI NAME. LAST	mcalothe	UN	4b. City	, Town, or Location of		7 3 Da	y Year Zes 4	3. Time of Death 19 226 PM
Funeral Director		5. Social Security Number 6. Se	XX 7. Age (In yrs	ENTER 6. last birthday Yrs.		r 1 Year If Under 2	4 Hrs. Min. March	h Birth	9. Bin 1940 Hob	thplace (State or Foreign punity) New Mexi
B Maryland a-f ahow	ctor	10a. State 10b. County Virginia Fairfax		city, Town or L airfax		ion				10d. Inside City Limits 1 ☐ Yes 2 No
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illed within 72 hours after death with the Maryland Hygiene. Hygiene ther than "naturel", or liens 23a or 28a-f ahow int, the Meulcal Examine must be notified a	by Funerai	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Dece If Yes, spi 1 Yes	dent of Hispanic Orig porty Cuban, Mexican, 2 No Specify:	in? (Specify Yes o Puerto Rican, etc	or No- .)	14. Race - Ame Black, Whit Specify: Cau	e. etc.
within 72 hours at ene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	e kind of w DO NOT	al Occupation ork done during most use retired)	of working		ind of Business Dlied Ca	^{Industry} reer Trainir
a la de	To Be Co	17. Father's Name (First, Middle, Last) L.W. McGlothlin	•			18. Mother Bess	s Name (First, Mi	nson		
es 1 ar of Hea of Hem of Item		19a. Informant's Name/Relationship (T. Virginia R. McG) 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	othlin Wife		Coming Strategy of Communication (National Communication)	s (Street and Number ounity Avel me of other place) tery Ja		rfax S	tatien,	Va . 22039
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens		F	Robert	nd Address of Facility J. Murph	y Funera	1 Home	,Inc.	
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- (10)		1 49	completed cause of death (It	em 23a) (Type	BAU	P16547	eruns	2123	16	
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			5602 Morning			to and take to 1		1 Year	Marke		O Date of Die			
	Funeral		5. Social Security Number 080-24-6274	6.Sex 1 ☐ M 25 ∑ 1F	7. Age (In yrs. 73	Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Da June 1	Year 9	30 Nev	hplace (State or Foreign
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	r 28a	rec	10e. Street and Number				10f. Zip	Code				10g. Cilize	en of What Co	ountry?
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	deat	ner	11. Marital Slatus	12. Was Dec	cedent Ever in U	l.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- 14	Race - Ame Black, White	
9	or Its	F	1 Never Married 2 Marri		2 No		1 ☐ Yes 2				, , , , , ,)	specify: Wh	
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yland	d be ental ked o	To Be	Carl C. Pe	rsson					Ka	aren	E. Jul	strom	1	
<u> </u>	shoul nd Ma marl	-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	er, City or	Town, State, 2	Zip Code)
Z	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Madical Examination to the continued.		Chris N. Kourt	sis, Sr.,	Friend	1 5602	Morr	ing	Gate	Ct.,	, New M	arket	, MD 2	1774
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Ē	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		State Smi	thsbur	g Cre	emato	ry pa	an. I	13, 200	4 Sm	iithsbu	urg. MD
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ב כ	ding P th. After t funera	on:	27. Manner of Death 1 ANatural 5 ☐ Pendin	g 28a. Date (Mo	e of Injury nth, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe h	now injury	occurred	
<u>s</u>	Attending Physician: r death. sctor: After this certific. by the funeral director,	cat	2 Accident investig 3 Suicide 6 Could r	ot be	o of Injury Al h	10000 10000 01	M (aster		Yes 2 🗌		296 Location /6	Stroot and	Number of Pr	um I Pouto Number
DIVISION	or At after of Direction by	Certification:	4 Homicide determ		e of Injury - Al h ding, elc. (Speci		reet, ractory	г, опісе			City or Tox		vumber or AL	ural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifyin	g Physician: To th	e best of my kn	owledge, deat	h occurred	at the tim	ne, date an	nd place s	and due to the	cause(s) a	nd manner as	s stated.
	e Hor 24 h e Fun etely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation	, in my or	oinion, dea	th occurre	ed at the time,	date and p	lace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certified	06	Ω		290		number			29d. Date	signed (Monti	h, Day, Year)
			> thorey.	Olm	ar int)		03	3176	. /		Jan	uary 1	2, 2004
7			30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type.	Print)	2 ~	vi CC		CAENC	0101		21701
_			21/4/10		MD 50		SEVE	NI	7 3/	',/	PHDA	CICK	MO	21 101
	Sta Registi		31. Date filed (Month, Day, Year)	1 2004	Registrar's Sign	ature	Lorge M.	D		/			r .	

Deborah M. Messier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-00319 State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item #23a,27,28a-f per me G828 2/5/2/1 tas of Death Registrar Registrar AKG 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 7:02 January 12, 2004 Deborah Marie Messier /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Brooklyn Park Anne Arundel 402 Orchard Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number **Funeral** 1 ☐ M 2 💢 F 49 Yrs 17,1954 Maryland 215-62-4093 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Maryland 10a. State 10h County rei', or itema 23a or 28a-f show Examiner must be notified at Anne Arundel 1 ☐ Yes 2 X No Maryland Brooklyn Park Direct the 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number with t 21225 USA 402 Orchard Avenue death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo !! Yes, Give Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 21215-0036 þ 3 Widowed 4 Divorced Year or Dates natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) than Office Administrator State of Maryland vears 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Health and Mental H tem 27 is marked of other traumatic ever Robert J. Messier Ida Mary Holt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David C. Kreimer/ Son 4721 River Haven Ct., Owings Mills, MD 21117 If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ᇹ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. 1-14-04 Kalas Crematory Edgewater, MD ⁴ 4 □ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home mit. 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Mixed drug intoxication /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ğ in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☑ Yes 1 X Yes 2∏ No 2 🗔 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6€ Other (Specify) At scene 1 ¥Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury 1/12/04 Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death After 5 Pending investigation 6:45 ury 1 Natural p 1 ☐ Yes 2X No 2 Accident Found Found unknown 6 X Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 402 Orchard Avenue 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Brooklyn Park, Maryland found at home

Box 68760. P.O. Division of Vital Records, 24 hours after death. filled in by completely within 2 To the

> State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

29b. Signature and title of certifier

on

Greenberg 31. Date filed (Month, Day Year) 32 Registrar's Signature

cenhere

111 Penn Street, Baltimore, Maryland 21201

MO

cause of death (4r m 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 13, 2004

		_	State of Marylar	nd / Departm	ent of Health ar	nd Mental Hy	giene		
	•	1 - For Amend Item 200 Registrar	State of Marylar per DVR,G827,0	01/21/04/hb	ate of Death		Reg. No.	2004	01383
Discrete:		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	aath Day	Year	3. Time of Death
Physici /Medio		EUNICE	SWAN	MILLE		Jan.	10,	2004	
Examir	ner	4a. Facility Name (If not institution, give st		4b. 6	City, Town, or Location of I			County of Dea	•
		Laurel Regional 5. Social Security Number 6. Sex	HOSPITAL 7. Age (in yrs.	last birthday) If U	Laure		th PI	9. Bir	George's
Funeral Director			M 2 ∏ F 92	Mon	ths Days Hours	Min. 8. Date of Bir (Month, Da	8/19	Co	nnsylvani
D		Usual Residence of Decedent	1.0.0	-					
arylar •how	5	10a. State 10b. County		ty, Town or Location		77.4.			10d. Inside City Limits 1 ☐ Yes 2 No
he M 28a-f	ectc	MD. Harf	ord	100	. Zip Code	llston	10a. Citi	zen of What Co	
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Medical Ezam narmust be notified at	Funeral Director	2120 Round Hil	1 Pond		2104	7		ted S	
death me 2;	era		2. Was Decedent Ever in U Armed Forces?	I.S. 13. Was D	ecedent of Hispanic Origin specify Cuban, Mexican, f	9		14. Race - Ame Black, Whit	erican Indian,
after or Ite	E.	1 Never Married 2 Married	1 ☐ Yes 2 MNo		specify Cubail, Mexicall, i	deno rican, etc.)		Consitu	
ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:						White
natu "natu	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give kind o	Usual Occupation If work done during most of OT use retired)	of working		nd of Business .nne	Industry
withir ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		Principal	1	-		County
ould be filed with Mental Hygiene arked other that atic event, that	Be C	17. Father's Name (First, Middle, Last)		7 011002	-	s Name (First, Middle	·		
Aenta Aenta rked tlc ev	To B	William Ernes	t Swan		Zol	la Fay		Trost	le
2 should and Men le marke aumatic	1	19a. Informant's Name/Relationship (Typ	0011		iress (Street and Number				
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It health and Mental Hygiene. Item 27 te marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exam har must be notified at		Christopher B.			ound Hill				Md. 21047
Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1	moval from State	Place of Disposition cemetery, crematory	or other place)	Date	Fall	cation - City or .ston ,MD	Town, State
		*4 □Donation 5 □Other (Specify)		ghview M		/15/2004			Muryland
permit. Departr Imports any inju		21. Signature of Funeral Service Ucense	Kinhi	22. Nam	e and Address of Facility	Jarrett			
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that haused the dear	th. Do not enter the		SON Fu		LI HOM	Approximate
Dharistan		shock, or heart failure. List only one Immediate Cause (Final							Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consec		r Acciden	Ū			3 days
Examiner									
7 5	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					•
acuter Ind trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec						
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal E	Todaking in doubly basis	Due to (or as a consec	querica or).					
ificate be e g physician as the buria		d.							realise and
certifical rding ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregn					23d. Date of de	livery
death cer e attendir ed for use	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of the		or (specify)			Month	Day Year
t the d	hys	9 Unknown	9□ Unknown						
requires that the	by P	Part II, Other significant conditions cont		-	ing cause given in Part I.				o the cause of death?
equir sen si ould t		Urinary Tr	act Infect	blon		_ 10	Yes 2	XNo 3□P	robably 4 Unknown
2 8 8	Completed					24a. Was	psy	prior to	utopsy findings available completion of cause of
ate pag	Sol					1 Tes	ormed? 2 No	death?	2 No
Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: Y		Othor	of Death (Check only			
hys this	- T	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 3[28b. Time of	28c. Injury at	sing Home 5 Res			icify)
fte all	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury M	Work?				
l or Attending after death. Director: Atte	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, street, fa	ictory, office	28f. Location ((Street an	d Number or R	ural Route Number,
s afte el Dir	Certification:	- I Torrioldo	building, etc. (3pec)	77/		Ony 0/ 10	, State	,	
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to			ician: To the best of my kn er: On the basis of examin						
the F hin 24 the F	Medical	one)	and manner stated.		29c. License number			e signed (Mon	
To To	-	29b. Signature and title of certifier	Land R. K.	ann					
		More particular pr	molecular of the time	7 U .	D0036716		Janu	ary 1	0, 2004
		30. Name and address of person who con	N/ D	217 (ha	rrv Lane	Laurel	IVI A	20'	707
St	ate	Andrew Kundrat,	- 32 Registrar's Sign	ature		naurel	, PIO		121
Regist		OMINATA	-004 Stelve	JA de	and a				

			1 _ For	State of Maryland	l / Depa		lealth and M	lental Hygie	ene 2001	01381
			Registrar			uncate of i	Jeani	2. Date of Death	. No	01001
H	Physicia /Medic		Decedent's Name (First, Middle, Last) Maric	on C	M	cAdams		January		
	Examin		4e. Fecility Name (If not institution, give s Frederick Memor			,	Location of Death rederick			derick
*	Funeral Director		5. Social Security Number 243-20-5886 6. Sex	M 2□F 7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y DeC •	28, 1923°	hplace (State or Foreign unity) North Caroli
	Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Fre	derick 10c. City,	Town or Lo				<u>,</u>	10d. Inside City Limits 1√2 Yes 2 □ No
:	3a or 28a	i Director	10e. Street and Number 2373 Bear Den Roa	d		10f. Zip Code	2170		. Citizen of What Co	untry?
030	be filed within 72 hours after death with the Maryland hal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Modical Examinal misal be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 Teb 19 If Yes, Give Year or Pares: Nov	. 13. 1 943 L945	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spin, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
20-0	a all	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work ()	ing	b. Kind of Business/	
7	a the same	E O	Elementary/decentary (5 12)	1	Elect	rician			Electrici	al Contracto
		To Be C	17. Father's Name (First, Middle, Last) Andrew J. McAd	ams			den Sumame) cerfield			
	ad 2 s		19a. Informant's Name/Relationship (Ty) Callie Oakes McAda						City or Town, State, 2 Maryland	
ம	Pages 1 and 1 nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pla ce Smili	ace of Dispo	sition (Name of		Dete 20	c. Location - City or	
Baitil	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service License	al Home Frederick	M 1 1					
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a consequence)	ence of):	Properties mode of dying	g, such as cardiac	or respiratory arrest	rrederren	Maryland Approximate Interval Between Onset and Death
68760,	Attending Physician: The law requires that the death certificate be executed right. The death. The death. The certor After this certificate has been signed by the attending physician and better tuneral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).						
P.O. Box	that the death certificate ted by the attending physic detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
ds, P.	ires that signed by I be deta	by	Part II. Other significant conditions con						cco use contribute to	the cause of death?
5	w requir been si should	etec		neture)			,		1	
II Rec	The law cate has t page 2 s	Completed		recese				24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Ħ	cian: artific actor.	Be	25. Was case referred to medical examiner?					(Check only one)		
\leq	hysi his c	၉	10 195 20/10	ospital: 1 Inpatient 2 E					ce 6 Other (Spec	cify)
Division of Vital Records,	ending P sath. or: After t he funera	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Wor	y at k? Yes 2 □No	28d. Describe how	injury occurred	
É	tal or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the tuneral director, page	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occuri	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Comp	M	29b. Signature and title of certifier	>/		29c. Licens			. Date signed (Month	2 (1
	(d)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	14628	6	07/7	, 2004 MD21701
·	Sta	te_	31. Date filed (Month, Pay, Year) 20	32. Magistrar's Signat		mark's	56 /	1 -= 4	7-1-1	11/2/1701

B.K.S DANIEL MOFOR-ACHIRI NGUNDAM

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg.	No. Z	004	A STEAM	38
Death	_		3. Time	of Death
	Dav	Year	1	

Phys	ician
/Me	dical .
Exan	niner

3. Time of Death

Birthplace (State or Foreign Country)

Black

10d. Inside City Limits

YYes 2□No

Funeral Director

28a-f show avent, the Medical Examinant start be notified at "natural", than

Director

the Maryland markad Health itam 27

by Funeral Baltimore, Maryland 21215-0036 Completed Be Pages 1 and 2 should be nent of Health and Mental ဥ permit. Pages Department of Important: If it any injury or o **Physician** /Medical **Examiner** Examiner The law requires that the death certificate be executed the burial-tran and Division of Vital Records, P.O. Box 68760, attending physicien Physiclan/Medical as use a Be Completed by 2 should be peen page certificate funeral director, Certification: To death. after death filled in by within 24 hours at To the Funaral D completely filled in To the Hospital Medical

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 02, DANIEL MOFOR ACHIRI NGUNDAM JAN. 2004 4b. City, Town, or Location of Death SILVER SPRING 4c. County of Death 4a Eacility Name (If not institution, give street and number)
BONIFANT ROAD & MORTON HALL ROAD MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
June 12, 1980 September 1980 Cameroon, W.A. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2□F 23 231-91-6229 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County Centerville Fairfax 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 14531 Oak Cluster Dr. 20120 Cameroon, W.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married □Yes 2 No Yes, Give If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student 2vrs none 17. Father's Name (First, Middle, Last) 18. Mother's Name /First, Middle, Maiden Sumame) Donald NGundam Grace Achu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14531 Oak Cluster Dr., Centerville, Va. 20120 Sarah N. Gwangwaa/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 1/24/04 Church Cemetery Bamenda, Cameroon W.A * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Funeral Service Licensee 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEDDO DISURIES Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy

in the past 12 months?

4□Pregnant at time of death 9 Unknown

5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to/completion of cause of death 1 Yes 2 No

25. Was case referred to medical miner? examiner/ 1∭XYes 2⊟No 27. Manner of Death

investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) [-2-04 28b. Time of Injury PUAD M

Cther: 4 \square Nursing Home 5 \square Residence 6XO ther (Specify) AT SCENE 28c. Injury at Work? 1 ☐ Yes 2 No

28d. Describe how injury occurred DELUSTROFOST DUPPSU WITH BUS

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ROPOWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State) BONIE SUTRIC MORTON HALLRDHOME, CHETY 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

1 Natural
2 Accident

29a. Certifier

29c. License number O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year) 3, 2004 JAN.

completed cause of death (Item 23a) (Type, Print) KOREU

MARLA QUID

31. Date filed (Month, Day, Year)

Monle

#32. Registrar's Signature

JAN 0 8 2004

State

Registrar

W

State Registrar

JAN 2 1 2004

32. Registrar's Signature

ORIGINAL

				0.0.0	ar y laire	Ce	rtificate	of L	Death	F	Reg. No. 2	104	01387
	0 Dhysisi		1. Decedent's Name (First, Middle, L.	ast)						2. Dete of Dee Month	th Dey	Year	3. Time of Death
-	Physicia /Medio		SHIRLEY	A. 0	DENWA	LD				JAN.		2004	6:05 AM
Ì	Examin		4e Fecility Name (If not institution, gi	ve street end number))			4	b. City, Town, o	r Location of Death	4c. County	of Deeth	
			HERITAGE HAR	BOUR HEAL	.TH				ANNAPO		ANNE	ARUN	DEL
	Funeral Director		579-48-5207	Sex 1	ge (In yrs. Ie 69	st birthday Yrs.	Months	Year Days	If Under 24 H Hours Mi		r, Year)	9. Birthp Coun P.	place (State or Foreign http)
	pue 🛊	ŀ	Usuel Residence of Decedent 10a. State 10b. County		10c, City.	Town or L	ocation					1	0d. Inside City Limits
	Aaryle Sho	5	,	DIMBET	,			T T A					Yos 2 □ No
	15 N 15 N 15 N 15 N 15 N 15 N 15 N 15 N	Director	MD. ANNE A	KUNDEL			ANNAPO				10g. Citizen of	What Cour	
	Kit of a	ā					101. 210 0		1.401		1910		uy:
	99th	era	2700 SOUTH	HAVEN RD.	Ever in U.S.	13	Was Decede		1401	Specify Yes or No-		S.A.	an Indian.
Maryland 21215-0020	be filed within 72 hours after deeth with the Marylend tel Hygiana. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funerai	1 Never Married 2 Married **Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ② If Yes, Give Year or Dates:	,		If Yes, specif			(Specify Yes or No- erto Rican, etc.)	Bla Specif	ck, White, o	
Ō	2 ho	Completed	15. Decedent's E	ducation (16a. Dece	dent's Usual	Occupa	ation		16b. Kind of B		
24	within 7 ana. than "n	9 9	(Specify only highest gr Elementary/Secondary (0-12)	rede c <i>ompleted)</i> College (1-4or:	5+)	life.	DO NOT use	done d retired,	furing most of w)	orking			
21	d and with	ĕ	12	oonogo (1 401 t	.,		H	OME	MAKER			HOME	
b	be filed tel Hygi d other evant,	Be	17. Father's Neme (First, Middle, Las	t)		· · - · ·	•		18. Mother's N	ame (First, Middle,	Maiden Surnar	пе)	
<u> a</u>	should be nd Mantel marked o	ToE	HENRY	PFLAGI	NG					ALICE	DOWDI	ΞN	
a	2 should end Man la marke		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ing Address (Street a	and Number or I	Rurel Route Numbe	r, City or Town,	State, Zip	Code)
Σ	alth alth		MIKE ODENWAL	D/SON		1282	1 HOL	IDA	Y LA.,	BOWIE, MD	. 20716	5	
re	一工 5 5	- 1	20a. Method of Disposition		cor	ce of Disp	osition (Name	of er place	e)	Date	20c. Location -	City or To	wn, State
Baltimore,	nit. Pages artment of I ortant: If Ita injury or o		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1 -		S CREM		•	1-5-04	RIVERI	DALE,	MD.
Bal	permit. Page Department. Important: if any injury or	1	21. Signature of Funeral Service Lign	mbeua	2 _{M00}	C	2. Name and HAMBER 801 CL	SF	UNERAL	HOME & CR E., RIVER	EMATORI DALE, N	UM,P.	.A. 0737
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The same	Physician		SHOOK, OF HEART SAILUTE. LIST OFFI	One cause on each	110.							†	Interval Between Onset and Death
and.	/Medical		Immediate Cause (Final disease or condition		51	MIK	0					!	4/
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	D =	ner			(.)		0	10)	i list	/			VIS
	cuter od rensi	Examiner	Sequentially list conditions.	b	Due to (or a	as a conse	quence of):) E. K	32 11 y				
oʻ	an el	严	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			į							
68760,	ficete be executed physician end is the bunel-trensit	edicai	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
39	E 00 0	8 S	resulting in death) Last										
Вох				d								+	
Э.	dea ne att	SCI	Part II. Other significent conditions	contributing to death b	ut not result	ing in the ເ	ınderlying cau	se give	n in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
P.O.	The law requires that the death ce ite hes been signed by the attendi paga 2 should be detached for use	Physician/	11 Agrica.	8.21.						1 □ Y	es 2 No	3 rob	pabiy 4 ☐ Unknown
	es th igner be d	þ	- Aylisa Jen	3)0/						-			
ord	v require been si should I	Completed	[2510 W	1 116	11)	1	(-eac.	0		24a. Wes e	n autopsy med?	ava	re autopsy findings allable prior to
Ö	elawr hesbe ga 2 sh	흕	/		<u> </u>		2 (2)					of d	npletion of cause death?
<u>د</u>	The la ate he paga	팃								1CY	s 2LINO	10	Yes 2□No
ita	ician: The		25. Was case referred to medical examiner?						26. Place of De	eath (Check only on	10)	1	
<u>></u>	Physician: rthis certific iral diractor,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 🗆 El	NOutpatie	nt 3□ DOA	Othe	er: 4 Nursing	Home 5 ☐ Reside	ence 6 Oth	er (Specify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, De	ry y Year) 2	8b. Time o	of 280	. Injury Work	et ?	28d. Describe ho	ow injury occur	red	
.00	Attanding ir death. actor: After by the fune	慧	2 ☐ Accident investigation				М	1 🗆 Y	res 2□No				
Division of Vital Records,	aftar deatl aftar deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, etc	ury - At hom c. (Specify)	e, farm, st	reet, factory, o	office		28f. Location (St City or Town		er or Rural	Route Number,
O	itai or irs afta rai Dir lied in	Ö	,										
	To the Hospital or Attanding Physician: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral diractor.	edicai	29a. Certifier (Check only one)	nysicien: To the best of miner: On the basis of and manner sta	examinatio	edge, deat n and/or in	h occurred at vestigation, in	the time my op	e, date and place inion, death occ	ce, and due to the ca curred at the time, d	ause(s) and ma ate and place,	inner as sta and due to	ated. the cause(s)
	To the to the company	Ž	29b. Signature end title of certifier				29c, L	icense	number	2	9d. Date signe	d (Month, E	Day, Year)
	(4)	N)			1,	14	17/8		1-2-	- 200	14
	The		30. Name end address of person who	1/1/1 /	eath (Item 2	3a) (Type,	Print)	1	110 1	A 21	1-2-	OWI	e us
	Stat	6	31. Dete filed (Month, Day, Year)	32/ Registro	er's Signatur	re .)/Ch,'	1011	10 /	(1,31.			20716
	Registra		JAN 0 5 200	14 Bearing	J. A.	A De	and a						

DHMH 16 Rev 6/95

			For S Sate Registrar	tate of Maryla		artment of H			giene Reg. No. 2 (304	010	388
	* Physicia		Decedent's Name (First, Middle, Last)	Richard	Dentor			2. Date of Dea Month Januar	ith Day	Yeer	3. Time of 0	Death M
	/Medic Examin		4a. Facility Name (If not institution, give street				r Location of Death		4c. Count	y of Death		
			Carroll Hospital Cer 5. Social Security Number 6. Sex		rs. last birthday)	Westmi		8. Date of Birtl (Month, De)			County place (State or	Foreign
	Funeral Director			2□ F	70 Yrs.	Months Days	Hours Min.		, Year) 1933	Mary		
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				1	l 0d. Inside Cit	y Limits
	the Marylar r 28a-f show	ctor	Maryland Carroll Co	ounty Ta	aneytown						1 X Yes	2 🗆 No
3	with the	Director	10e. Street and Number 211 East Baltimore	Stroot		10f. Zip Code 21787			10g. Citizen of		•	
1	death w ms 23a	Funeral		Was Decedent Ever i	n U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		ce - Americ	can Indian,	
H 38	within 72 hours after death with the Maryland one of the matural; or items 23s or 28s-1 show the Modical Examiner must be multified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Novorced	Armed Forces? 1 ☑Yes 2 ☐ No 1 If Yes, Give Year or Dates:	955-	if Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	Hican, etc.)		ick, White, fy: Whi		
RIC F	72 hours natural;		15. Decedent's Education (Specify only highest grade co	on	16a. Dece	dent's Usual Occupa	ation	sina	16b. Kind of E	łusiness/In	dustry	
212	d within 7 piene. r than "r the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	ory worke:	1)	9	manufa	cturi	na	
Q D	be filed with stat Hygiene of other tha event, the	0	10 17. Father's Name (First, Middle, Last)		2000	727023.0	18. Mother's Nam	e (First, Middle,			.119	
W B	2 9 2 2	To B	Clarence D. Ohler					t E. Ba				
Mary	12 s h ar 7 is trau		19a. Informant's Name/Relationship (Type, Denise Kay Tatum /			ng Address (Street a		a <i>l Route Numbe</i> :tlestow				340
	es 1 and of Health filem 27		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Rem	20	b. Place of Dispo			Date	20c. Location			<u> </u>
()	permit. Pages Department of I Important: If it any injury or o		* 4 □ Donation 5 □ Other (Specify)	G		C.C. Cemet	cery	2004	Taneyto		Marylan	d ———
8	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	wi		2. Name and Addres 36 East Ba	altimore	iles Fu Street			MD 21	787
	《美		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the cause on each line.	leath. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACUTO	sequence of):	SPIRF	TORY	(A)	LUR	E		
	Examiner		Sequentially list conditions b	BILAT	ERA	L PA	IEUM,	ONIF	7			
	bet nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):	301011	1 11/1	1/1/1	e DI	3(1)	0,-	
d	ate be executed hysician and the burial-transit	Exar	that initiated events c. Cresulting in death) Last	Due to (or as a con	sequence of):	2) INU		6617	9 +1	26/1	56	-
8760.	the type	dlcai	d . ±									
9 X C	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pre		75			23d. D	ate of delive	ery	
Division of Vital Records. P.O. Box	the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death certificate hin 24 hours after death certificate has been signed by the attending propletely filled in by the funeral director, page 2 should be detached for use as a	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F 4 Pregnant at time 9 Unknown		Ectopic pregnancy Other (specify)			М	onth	Day Y	ear
۵	es that the de igned by the be detached	by Phy	Part II. Other significant conditions contrib	outing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of de	ath?
ords	w requires been sign should be	ted b	ALLITE KER	YAL	MIL	URE		1 🗆 Y	es 2□No	3 🗆 Prot	pably 4 Du	nknown
Seco	e law r has be je 2 sh	Completed	MYEMIA	-F	4 0 4	0	~	24a. Was autop perfo	an 24b.	Were auto prior to co death?	ppsy findings a impletion of ca	variable ruse of
<u></u>	ician: The l certificate harector, page	O	25. Was case referred to edical	16511	MAL	BLE	26. Place of Dear	7 1□ Yes	2 No	1 🗆 Yes	2 No	
, ,	hysici his cer il direct	To B	examiner? 1 Yes 2 No Hos	1 of inpatient	2 ER/Outpatier		er: 4 🗆 Nursing H	ome 5□Resid	lence 6 Ot		fy)	
ouo	ding Phys	tion:	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dife of Injury (Month, Day Yea	r) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occu	rred		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Could not be	28e. Place of Injury - A building, etc. (Sp	At home, farm, str necify)	reet, factory, office		28f. Location (S City or Tox		ber or Rura	al Route Numb) <i>9r</i> ,
	ppital o		29a. Certifier Certifying Physici	en: To the best of my	knowledge, deat	h occurred at the tin	ne, date and place.	and due to the	cause(s) and m	nanner as s	stated	
	he Hos in 24 h he Fur pletely	edical	(Check only 2 Medicel Examiner one)									
	To t To t	Σ	29b. Signature and title of certifier		115	29c. Licens	e number)	29d. Date sign	ed (Month,	Day, Year)	
	(nd		30. Name and addless of person who comp	eleted cause of death	(Item 23a) (Type.	Print)		DEVINO	B & m	1203	21	117.
	W		HAI-EEZ H	SYED	20 C	ROGGR	0A1)3	DR, S	WIE	102	M	0
	Sta Regist		/31. Date filed (Month, Day, Year)	'32/Registrar's S	ignature	and i		,		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#'s 28b.& c.Per MEO FGC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 1021 AM Unga roubon 10 /Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Adams Cowiey Shock Trauma Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XX M 2□ F Months 23 224-93-0093 Director Aug. 19, 1980 Cameroon, W.A. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mentat Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified an once. 1 X Yes 2 □ No Va. Fairfax Centerville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20120 Cameroon, W.A. 14531 Oak Cluster Dr. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Student 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lamy Poubom ဥ Christina Fri NGundam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14531 Oak Cluster Dr., Centerville, Va. 20120 Sarah Gwangwaa/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/24/04 Bamenda, Cameroon, W.A. Church Cemetery 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signatura of Funeral Service Lice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Blunt disease or condition resulting in death) traun /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 8:49 AM 1 Natural 5 Pending investigation 1 ☐ Yes 2XXNo death. 24 motor vehicle 2 Accident crash 2 within 24 hours after deatl To the Funeral Director: in by the 3 🗌 Suicide 6 Could not be determined

288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

286. Location (Street and Number or Rural Route Number of Rural Route Number of Rural Route Number of Town, State)

287. Location (Street and Number or Rural Route Number of Town, State)

288. Location (Street and Number or Rural Route Number of Town, State)

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289. Location (Street and Number of Town, State)

289. Location (Street a 6 ☐ Could not be 4 Homicide filled Hospital 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 046147 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hillian L. Clin State

DHMH 17 Rev 1/2001

Registrar

	•	For State Registrar	State of Mary			nt of He <i>te of D</i> e		Mental H	ygiene Reg. No	2001	0139
Physicia /Medica	_	1. Decedent's Name (First, Middle, Last Madeleine Agne		on .				2. Date of I Month Januar	Da		3. Time of Death 4:00 A
Examine		4a. Fecility Name (If not institution, give Crofton Convale		er	4b. City	Crof			40	. County of Deeth	
Funeral Director		5. Social Security Number 6. Se 579-42-8199	X 7. Age (In	n yrs. last birthday) 85 Yrs.	If Under		f Under 24 H Hours Mi	n. (Month,	Birth Day, Year) 31,1	9. Birth Cou Vi	place (State or Forei intry) rginia
natural, or items 23a or 28e-f show dical Examiner must be notified at	ctor	10a. State 10b. County MD Anne Arun		10c. City, Town or Location Gambrills						10d. Inside	
s 23a or 2	Funeral Director	10e. Street and Number 1720 Basil Way					1054		U	tizen of What Cou SA	
al', or item Examinar n	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deci f Yes, sp 1 ☐ Yes	ecify Cuban, I	anic Origin? Mexican, Pue Specify:	(Specify Yes or I erto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh:	
Department of Health and Mental Hygiene Important, or Items 23a or 28e-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Madical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give	kind of w	ual Occupation ork done duri use retired)	on ing most of w	rorking		ind of Business/Ir	ndustry
Mental Hygie rked other itic event, II	To Be Co	17. Father's Name (First, Middle, Last) Byron Rolston		IIOI	iciiak		3. Mother's N. Jesse	ame (First, Midd			
aalth and h n 27 is me er traume	1	19a. Informant's Name/Relationship (T) Shirley Verdonck	/ daughter	1720	Basi	1 Way	Number or I			or Town, State, Zi	
ment of He ant: If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)		20b. Place of Dispo cemetery, crei Metropoli			ory 1-	Date -6-2004	10	ocation - City or T	
Departr Imports any inji		21. Signature of Funeral Service Licens		22	. Name a	nd Address o	of Facility	Beall F Bowie	unera	1 Home	
ysician Medical was the private and standard transit t	Exal	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tary, loading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	ive Heart			uch as caru	ac or respiratory	arrest,		Approximate interval Between Onset and Death 2 years
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Moo 9 Unknown	d	Fetal death 3	Ectopic p	oregnancy pecify)			23d. Date of delivery Month Day		-
ed be d	ò	Part II. Other significant conditions cor Diabetes	contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the car		
ate has	Completed							per 1 ☐ Yes	opsy formed? 212 No	24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings availa impletion of cause of 2 □ No
h. After this funeral di	No B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye.		OA Other: 28c. Injury at Work?		Home 5 Res	sidence (5 □Other (Specification)	(y)	
within 24 hours after death To the Funerat Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined						28f. Location City or To	(Street and	d Number or Rura)	al Route Number,
in 24 hou the Funer	edical	one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred	at the time, on, in my opinion	date and place on, death occ	e, and due to the curred at the time	e cause(s) e, date and	and manner as s place, and due to	tated the cause(s)
within 2 To the I		29b. Signature and title of certifier	1		29	c. License nu D3584				e signed <i>(Month,</i> luary 5,	**
7 1		30. Name and ddress of person who co Howard K. Schult		(Item 23a) (Type, 438 Defer	Print)			77.0		-5:	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 3, 2004 Perry January 7:51 A.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death nder 24 Hrs. Min. Prince George's

Birthplace (State or Foreign Country)

Florence, S.C.

U.S.A. 14. Race - American Indian, Black, White, etc.

Private Industry

20c. Location - City or Town, State

10d. Inside City Limits 1 Types 2 □ No

Physician /Medical Examiner

Dorether

Funeral

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

ng physician and as the buriel-transit or Attending Physician: The law requires that the death certificate be executed attending | page 2 s After this ā filled in by completely To the P within 24 To the F

ို

Medical Certification:

1 Yes 2 No

5 ☐ Pending investigation

6 Could not be determined

Paul A. Devore, M.D.

Day, Year) 7 2004

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760,

	Manor Ca	are Healt	h Care	Center				Larg	0	,	Princ	e Ge	orge	
	5. Social Security N		Sex 1 □ M 24534F	7. Age (In yrs		Months Months		If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Da <i>y</i> , Yea <i>r)</i>	9. Bir	thplace (S	
	579-10-1	666	ILIM ALA	95	Yrs.					10/3/			oren	
	Usual Residence of				T									
_	10a. State	10b. County	1		ity, Town or L		'						10d. ins	
Ş	Md.	Prince (George'	S	Cap	itol	Heig	hts					15	
ire	10e. Street and Nu	mber				10f. Zip	Code				10g. Citizen of	What Co	ountry?	
<u>a</u>	5127 Du	el Place						2074	13		1	U.S.A.		
ne	11. Marital Status		12. Was Dec Armed F	cedent Ever in torces?	J,S. 13.	Was Dece	dent of H	lispanic O	igin? (Sp	ecify Yes or N Rican, etc.)	lo- 14. Ra	ce - Ame	erican Indi	
昰	1 Never Marr	ied 2□ Married	1 ☐ Yes	2 XNo						riicari, etc.;				
Ď	3 🖎 Widowed	4 Divorced	if Yes, G Year or I	Dates:		1 ☐ Yes	ZIXINO	Specify	•		Spec	Specify: Black		
Completed by Funeral Director	(Ѕрво	15. Decedent's E hify only highest gr)	16a. Dece	dent's Usua kind of wo DO NOT u	al Occup	ation during mo	st of work	king	16b. Kind of Business/Industry			
Ē	Elementary/Seco	ndary (0-12)	College	llege (1-4or 5+)										
ပိ	3rd	(First Middle 1 and		Laundress						- (Final 11:11)	Private e, Maiden Surna		austr	
Be	17. Father's Name		_					_				me)		
ဥ	French	Muldrow,	Sr.					Saı	can E	Burnett	e			
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R									al Route Num	ber, City or Tow	n, State, 2	Zip Code)	
1	Willia K	. Hammon	s/Niece	13.75	2212	Lake	wood	St.	Suit	land.	Md. 207	46		
	20a. Method of Disp	position		20b.	Place of Dispo cemetery, cre	osition (Nar	me of			Date	20c. Location		Town, Sta	
		Cremation 3		State	13	8000W			İ					
		5 Other (Special		Ma	ryland	Vete 2. Namøar	rans	_Cem.		/12/04	Chelte	nham	Md	
	21. Signature of Fu	neral Service Lice	risee			H.S.V	vash:	inato	n &	Sons Co	o.,Inc.			
	4925 Burroughs Ave. N.E. Wash. D.C.											C	2001	
	23a. Part1. Enter t	he disease, or com	plications that	caused the dea	th. Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory	arrest,	,.C.	ADDro	
	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. An TENUE CUSTOFIC CANDI OVASCULAR Due to (or as a consequence of):												Interv Onset	
	Immediate Cause (Final	An	76111	11/12		10	40		0-1-1	1 1	000		
	disease or condition resulting in death)	n	a. / 1/t	10100	d CO	NOTE		4751.	OUA	8CUI AL	1 1-11-4	451	- 4	
<u>~</u>				Due to (or as a conse	quence of):								
듣			b											
xar	Sequentially list co if any, leading to in	nditions,		Due to (or as a conse	quence of):								
<u>H</u>	cause. Enter Unde Cause (Disease or	erlying	•											
S	that initiated events resulting in death) I		Due to (or as a consequence of):											
<u>e</u>														
5			d											
5	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did	tobacco use c	ontribute	to the ca	
nys	2										Yea 2 No	3 □ P		
₹	Dem	entia						·		,,,	rea zyz(No	3 P	Obably	
Completed by Physiclan/Medical Examiner	11	erte								24a Wa	s an autopsy	24h	Were auto	
e e	Hy	erte	ndior	1						perf	formed?		available i	
출	1	· · · · · · · · · · · · · · · · · · ·										of d		
ह										10	YES 2016	ļ.,	1∐Yet	
Bec	25. Was case refer	red to medical						26. Plac	of Deat	h (Check only	one)			

hs Ave., N.E., Wash., D.C. 20019 has cardiac or respiratory arrest, Approxi art I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 ☐ Probabiy 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TO YES 20 NO †∐Yet 2∐No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) JANUARY 4. 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4203 Queensbury Rd., Hyattsville, Md. 20781

State Registrar

DHMH 16 Rev 6/95

			For State Registrar	State of Maryland	/ Depa		ealth and I	Mental Hy		2001	01392
	Physici		1. Decedent's Name (First, Middle, Last) David Charles	Piper				2. Date of De Month Jan.	ath	2004 ^{Year}	3. Time of Death 12:36 A ^M
	/Medio		4a. Facility Name (If not institution, give s	oad		Cumber1			4c.	County of Death	
	Funeral Director		5. Social Security Number 220-80-8942 Usual Residence of Decedent	M 2 F 7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar	10, 19	9. Birth Co.	place (State or Foreign intry)
	Maryland -f show	tor	10a. State MD Allegany	10c. City, T		cation Derland					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3e or 28a	Funeral Director	10e. Street and Number 12613 Limestone R	load SE		10f. Zip Code	21502		10g. Citi	zen of What Cou	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funera	11. Marital Status 1 A Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 D No If Yes, Give Year or Dates:	Vas Decedent of Hi i Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	Decify Yes or No Decify Yes or No Decify Yes		14. Race - Amer Black, White Specify: Wh	, etc.	
21215-0036	ithin 72 ho ne. nen "netu	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done o OO NOT use retired	ation furing most of word)	king	16b. Kii	nd of Business/Ir	ndustry
Maryland 21	uld be filed wi Aental Hygien rked other th tic event, the	To Be Con	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)							Sumame)	
Mary	ind 2 should alth and Men 27 is marke or traumatic		19a. Informant's Name/Relationship (Type Viola Piper	mother	19b. Mailin	g Address (Street a	one Road	ral Route Numb Cumb			MD 21502
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Ri 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place ceme Hartso	ock Ce	sition (Name of natory or other place emetery	ļ	Date 1/19/2004		cation - City or T	own, State
Balt	permit. Departimport any inj		21. Signature of Funeral Service License	1. Nauselli	18	Name and Address Scarpelli 108 Virg	inia Avenue	. Cumbei	rland.	MD 21502	,
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Arterioscler Due to (or as a consequent	otic	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	te be executed ysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen-							
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)			2	3d. Date of deliv Month	ery Day Year
ds, P.	uires that signed b	ρ	Part II. Other significant conditions con Pulmonary Hyperi		g in the ur	iderlying cause give	n in Part I.		obacco u: Yes 2 🗆		he cause of death?
Vital Records,	The law requir cate has been si page 2 should t	Completed	Essential Hyper	tension				24a. Was autor perfo 1 □ Yes		24b. Were auto	opsy findings available impletion of cause of
Vital		Be	25. Was case referred to medical examiner?	ospital:	-	2□ DOA Othe	26. Place of Dea	th (Check only o	one)		
ð	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certification in the funerel Director: After this certification in by the funeral director.	ation; To	27. Manner of Death Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ ER/ 28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work	at	28d. Des vibe l		☐Other (Special occurred	(y)
Division	a Hospital or Attend 24 hours after death 5 Funerel Director: etely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (: City or Tox	Street and wn, State)	d Number or Run	al Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dirr completely filled in It	edical	29a. Certifier (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) date and	and manner as s place, and due t	tated. o the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. License				signed (Month,	
			30. Name and address of person who col	mpleted cause of death (Item 23	a) (Type, I	DO915	o /		Janu	ary 15,	2004
			Paul Snow, M.D.;	32 Angietrar's Signature		۵	nd, MD 2	21502			
	Sta Registr		31. Date filed (Month, Day, Year) 200)4 32. Hogistrar's Signature	A. S. S. S. S. S. S. S. S. S. S. S. S. S.	ede					

	1-	For State Registrar	State of	f Marylan	•	artment o			and Me		giene 10g. No. 2 (201	0139
Phỳsician	_	Decedent's Name (First, Middle, L	,	EV				-		Date of Dea Month	th Day	Year	3, Time of Death
/Medical Examiner	4 -	SISTER JUS Facility Name (If not institution, g ST. VINCENT CA	ive street and num	nber)		4b. City, To		Location o		ANUARI	1	ty of Death DERICK	
Funeral Director	_1	Social Security Number 6. L34-40-1908 sual Residence of Decedent	Sex 1□M 2∏F	7. Age (In yrs. I 92	V	If Under 1 Months E	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day JG. 26	Year) , 1911	Cou	place <i>(State or Forei</i> ntry) YLAND
Hygiene. the than "natural, or Items 23e or 28e-f show out, the Medical Examiner canst be notified at or Completed by Funeral Director	10	a. State 10b. County MD FREDE	RICK		y, Town or Lo								10d. Inside City Lim
3a or 26 If be no i Dire	10	e. Street and Number 335 SOUTH SETO	N AVE			10f. Zip Co				1	10g. Citizen o		ntry?
*natural; or items 23e or 28e-f ehov idical Examiner must be notified at leted by Funeral Director		. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For	2 ⊠ No e		Was Decedent I Yes, specify	nt of His Cuban	spanic Origin, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Ra Bf	ace - Ameri ack, White,	etc.
Hygiene. other than "naturn ant, it e Medical E er Completed		15. Decedent's (Specify only highest g	Education rade completed) College (1:		(Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired) PEACHER					16b. Kind of Business/Industry RELIGIOUS COMMUNITY DAUGHTERS OF CHARIT		
Mental Hygiene. marked other than imatic event, the M. To Be Comp	17	. Father's Name (First, Middle, Las FABIAN PO	SEY						LAURE	TTA RC	Maiden Suma DHRBACK		
f Health ar item 27 is other trau		SISTER CAMILLA a. Method of Disposition	HARANT	1 00	333 lace of Dispo		ON of	AVE.,		TSBURG	r, City or Town MD. 20c. Location	21727	
Department of Importent: If It It It It It It It It It It It It It	4	1 King British 2 Cremation 3 Chemoval from State										MD. 217	
physician and the burial-transit repeated in the burial-transit repeated in the burial-transit repeated in the burial-transit repeated in the burial repeated in	Se if a ca Ca tha	sease or condition soutling in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. AL Due to (c	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a con	I ME	RIS	-			,	SEAS		Tyear Freak
ed by the attending physicathed for use as the	IF 23	FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		irth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregr Other (specia					1	ate of defive	əry Day Year
been signed b should be deta leted by Ph	Pa	त ॥. Other significant conditions	contributing to de	eath but not resu	ulting in the u	nderlying caus	se giver	n in Part I.			oacco use cor es 2 X No		ne cause of death?
2 2 3										24a. Was a autops perform	v	Were auto prior to co death? 1 \(\text{Yes}	psy findings availa mpletion of cause of
is certificate his director, page	i	. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	anationt 2 1	ER/Outpetion	t 3 DOA	Other	,		heck only on	2011		
death. tor: After th the funeral	1 Inpatient 2 EN/Outpatien							at	28d.	Describe ho	ence 6 Ot ow injury occu	rred	J Route Number.
		4 ☐ Homicide determine Pa. Certifier 1 ☐ Certifying F	bullain hysician: To the	ng, etc. (Specify,	wledge, death	occurred at t	he time	, date and	d place, and	due to the ca	n, State)	anner as s	ated
within 24 hou. To the Fune completely fit		(Check only 2 Medical Example) b. Signature and title of certifier	miner: On the ba and mann	isis of examinati	ion and/or inv	restigation, in	my opi	nion, death	h occurred a	at the time, da	ate and place	, and due to	the cause(s)
)	30	Name and address of person who	completed cause	e of death (ftem	3a) (Type,	Print)	52	WA	TER	STR	227	-20	04
State	B 31	Date filed (Month, Day, Year)	ufCL-	PORTI	ERD ure	0. 7	HI	IRU	IONT	, w	102	178	8

			For State Registrar		State of I	Marylar		artment rtificate				F	leg. No.	2001	01394	
	Physici /Medi		Wilfredo Perez									2. Date of Dea Month Januar	Day	2004	3. Time of Death 7:20 A	
	Examir		4a. Facility Name (If not in 3049 Kather	ine Pla	ce				llico	Location of I	ty	Date of Birth		County of Dear Howard		
4	Funeral Director		5. Social Security Numbe 253 62 1821 Usual Residence of Dece	1 🔯	M 2 F	85	last birthday) Yrs.	Months	Days		Min.	B. Date of Birth (Month, Day Dec 16		18 Pue	hplace (State or Foreign buntry) erto Rico	
	the Maryland 28a-f ehow	Director	MD Howard Ellicott City								10- 01-	en of What Co	10d. Inside City Limits 1 ☐ Yes 2 XNo			
	with with the	i Di	3049 Kather	ine Plac	ce			10f. Zip	.042					ited St	•	
036	I within 72 hours after death with the Maryland itene. r then "natural", or Items 23a or 28a-1 ehow the Medical Examener wast be morified at	d by Funeral	11. Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ □	Married Divorced	Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1939-69 Mucation 16a. Decede (Give kilife) 16b.			Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, et IX Yes 2 No Specify: Puerto 1 dent's Usual Occupation kind of work done during most of working DO NOT use retired) Ler Sergeant				ican, etc.)	1	ncan Indian, e, etc.		
21215-0036	within 72 ene. then "net	Completed		Decedent's Educ by highest grade (0-12)										d of Business/ Army	Industry	
Baltimore, Maryland 2	be filed ntal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Juan Nepomuceno Perez							18. Mother's	,	First, Middle,				
	nd 2 shallth and 27 io n		19a. Informant's Name/R										-	Town, State, 2		
	Pages 1 and the total the		20a. Method of Dispositio 1 □ Burial 2 □ Cre 1 □ Donation 5 □ 0	mation 3 □Re	moval from Sta	te C	Place of Dispo- cemetery, crem umbia	sition (Nam natory or oti	e of her place)	Dat	te	20c. Loc	ation - City or ksvill	Town, State	
Balt	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral	Service License	200 - V	M9104		. Name and	d Addres	s of Facility I Olumb	Harry ia P	y H. Wi ike ElJ	tzke .icot	e's Fam	ily FH Inc. , MD 21043	
	Physician /Medical		23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or complic ire. List only one a.	e cause on each	n line.	FONA	er the mode	of dying	, such as ca	ardiac or i	respiratory arr D じ		(E)	Approximate Interval Between Onset and Death	
3760,	ate be executed by the burial-transit burial-transi	Icai Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ate 📕	Due to (or	as a conseq as a conseq as a conseq as a conseq	uence of): MARE	BFO	VK	WIA) istasi	-		qyRj.	
P.O. Box 68	death certific e attending p id for use as i	Physician/Med	IF FEMALE: 23b. Was decedent preginthe past 12 month 1 Yes 2 No 9 Unknown	nant	23c. If yes, outcome of pregnancy 1								23	3d. Date of deli Month	very Day Year	
	90	þ	Part II, Other significant	conditions cont	ributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.			oacco us		the cause of death?	
al Records,	The law ate has b page 2 s	Completed										ned?	24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of		
Division of Vital	ding Phys h. After this funeral dii	ation; To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	197	spital: 1 lnpa 28a. Date of li (Month, l		ER/Outpatient 28b. Time of Injury		c. injury Work	r: 4 □ Nursi at	ing Home	Check only on 5 TReside d. Describe ho	ence 6	□Other (Spec	ify)	
Divis	5 # # 5	Certification;	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28	281. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Certifying Physi Medical Examina	cian: To the be er: On the basis and manner	of examina	wledge, death tion and/or inv	estigation, i	in my op	inion, death	place, and occurred	d due to the ca at the time, d	ause(s) a ate and p	ind manner as place, and due	stated. to the cause(s)	
)	To t To t	2	29b. Signature and title o	f certifier	du	1			License			2		signed (Month		
2) 02	ij	30. Name and address of	person who con	pleted cause o	(Iten	n 23a) (Type, I	Print)	66	14 0	er	NA L		T) 210		
	Sta Registi		31. Date filed (Month, Da	y, Year)	32. Regi	st s.Signa	iture	Some	ويما		Col	umbit	-mi	210	44	

			For	State of Ma	ryland					nd M	ental Hyg	iene	2001	01005
			State Registrar			Cer	tificate	or L	eath		2. Date of Deat	g. No.	1004	2 Time of Booth
	Physicia	an	Decedent's Name (First, Middle, Last)								Month	Day	Yeer	3. Time of Death
	/Medic		Sallie B. Reav				45 005	Faura 1		(Death	January	_	2004 ounty of Deet	6:25 A M
	Examin	er	4a. Facility Name (If not institution, give :		•			fton	ocation of	Dean			e Arun	
			Crofton Convalesce 5. Social Security Number 6. Sep	7 Age		ist birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth (Month, Day,			nplace (State or Foreign untry)
	Funeral Director		263-22 - 0473	M 2014	83	Yrs.	Months	Days	Hours	Min.	(Month, Day, Aug. 9,	1920	Vir	ginia
- 0			Usual Residence of Decedent											24
	how		10a. State 10b. County		10c. City,	Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🗓 No
- 3	89-1-8	cto	MD Anne Aru	ndel		Odent	_							
3	Or 2	Dire	10e. Street and Number				10f. Żip				1	-	n of What Co	untry?
	e 23e	Funeral Director	1201 Collins Ave	12. Was Decedent B	Suprio II C	12.1	Mas Doord		1113	in? (Sne	scifu Ves or No-	US	A . Race - Ame	rican Indian
	E E	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		, 13.	f Yes, spec	ify Cuban	, Mexican,	Puerto I	cify Yes or No- Rican, etc.)		Black, White	e, etc.
50	be lied within 72 nouts after death with the Maryland tall Hygiene. Ad other than "naturel", or Iteme 23e or 28e-1 ahow event, the Modical Examitive must be notified at	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1	1 ☐ Yes 2	2⊠ No	Specify:			S	pecify: B1a	ck
5	z no	Completed	15. Decedent's Edu (Specify only highest grad	cation e. completed)		16a. Deced	dent's Usua	l Occupat	ion uring most	of workir	na	16b. Kind	of Business/	Industry
V	Man Tr	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	kind of wor DO NOT us		· · · · · ·			D		
7	ygien ygien her th	Co	8				Maid		19 Motho	r'a Nama	(First, Middle, I		nestic	
Vialia	od off	Be	17. Father's Name (First, Middle, Last) Thomas Peterson							ry H:		Maiuen St	mame)	
4	nd Meni	ဥ	19a Informant's Name/Relationship (Ty	roa Print)		10h Mailin	a Address	(Street ar			I Route Number	City or T	own State 7	in Code)
=	d 2 sr th and 7 to n troun		Virginia Mays/ sis				Webst				ashingto			0017
D .	Health tem 27 other to		20a. Method of Disposition		20b. Pla	L ace of Dispo metery, cren	sition (Nam	ne of					tion - City or	Town, State
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the warylan toporthent of Health and Mental Hygiene. Inportant: If them 27 is marked other than "naturel", or Iteme 23e or 28e-1 ahow any injury or other treumatic event, the Madical Examinar must be notified at once.		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State		ropoli			·	1-7-	-2004	Alex	andria	. VA.
baitimor	mit. 2 Sartm Sortsi / injui		21. Signature of Funeral Service Licens	90	1 1	-	. Name an				eall Fur			, , , , , , , , , , , , , , , , , , , ,
Ď	Depa Impo any ir		Krian	Your	U.	65	12 NV	V Cra	in Hy	√y.	Bowie,	MD.	20715	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death.	. Do not ent	er the mode	e of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition	\mathcal{C}	21	bro	ova	5 Cin	lan	Ac	ccide	X		10 years
	/Medical Examiner		resulting in death)	Due to (or as a	a consequ									J
		_	Sequentially list conditions,	b Due to (or as a	consequ	ence of):								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
,	be executed icien and burial-transit	Exa	resulting in death) Last	Due to (or as a	a consequ	ence of):								
-	that the death certificate be executed et by the attending physicien and detached for use as the burial-transit	cal		d										
0	certifica Iding ph	Medi	IF FEMALE:											
X D	th ce tendii r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pr	egnancy				23	d. Date of deli Month	ivery Day Year
	e death the atter ned for u	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐Pregnant at 9☐Unknown	time of de	ath 5□	Other (sp	ecify)					Wichter	Day Tour
Į.	hat th od by setacl		Part II. Other significant conditions co	ntributing to death bu	ut not resu	Iting in the u	nderlying c	ause giver	n in Part I.		23e. Did tot	acco use	contribute to	the cause of death?
ds,	w requires that the s been signed by th should be detache	d by		•			, ,				1 □ Y	s 2 🗆	No 3□Pr	obably 4 Oknknown
coras		Completed									24a. Was a	0	24b. Were au	topsy findings available
d)	ela has	m d m									autops	y ned?	prior to death?	completion of cause of
	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes		1 1 165	2 110
5		OB	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	nt 2 🗆 E	ER/Outpatien	nt 3 DC	Other			me 5 Reside		☐Other (Spec	cify)
	ig Phys ter this neral di	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	2	8c. Injury Work			28d. Describe ho			
DIVISION	Attending F ir death. ector: After by the funera	atlc	2 Accident investigation				М	1 🗆 Y	es 2 🗆 f					
Š	or Attenation or Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At hor c. (Specify	me, farm, str ')	eet, factory	, office		1	28f. Location (St City or Town		Number or Ru	iral Route Number,
_	pitel o	Ce	29a. Certifier 1 Certifying Phy	sicien: To the best of	of my know	vledge deatl	h occurred	at the time	o dato and	d plane 1	and due to the e	2000/01 20	d mannar ac	etatod
	Ne Hospitel or At 124 hours after d Re Funerel Direct bletely filled in by	Medical	(Check only 2 Medical Exami	iner: On the basis of	examinati	ion and/or in	vestigation	, in my op	inion, deat	th occurr	ed at the time, d	ate and p	ace, and due	to the cause(s)
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by the	Me	29b. Signature and title of certifier	. //				. License			2	9d. Date :	signed (Mont)	n, Dey, Year)
			Hours 110	to mi	D			113	584	8		117	7/01	1
R	(1)		30. Name and address of person who c	omblered cause of d	eath (Item	23а) (Туре,							11.	MODIOSY
			31 Date filed (Month Day Year)	Mall 2 32. Registra	ar's Signat	J 4	301	181	ens.	e H	ny Ga	im	orilly.	mwy os 7
15	Sta	ate	31. Date filed (Month, Day, Year)	Sz. riegistra	K	Rosal	60				V			

_			1 - For State Registrar	State of Maryla	and / Dep		ealth and	•	ygiene Reg. No. 2001	, 01396
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day Year	3. Time of Death
	/Medi	ROSA MAE RAWlings Jan 02								11:10P M
	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or		ith	4c. County of Deet	
			Prince George's			Chever			Prince G	eorge's
	Funeral Director		5. Social Security Number 175-16-2005 Usual Residence of Decedent	7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of B (Month, D Dec 1	irth Pay, Year) 9. Birth Co 9, 1920 Pen:	nplace (Stete or Foreign untry) nsylvania
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	d within 72 hours after death with the Maryland jiene. r than "natural", or Iteme 23a or 28a-f show the Medical Exantine Coust be Excitted at	to	MD Prince Ge	orge's I	Sanham					1 ∑Yes 2 ☐ No
	r 288	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	h with	Funeral Director	8200 Good Luck	Road		20706			United Sta	tes America
	ф	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Specify Yes or N	o- 14. Race - Ame	
9	after or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 【XNo	Specify:	no Alcan, etc.)		
8	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:		10 105 2 100	эрөспу.		Specify: B1	ack
21215-0036	natu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired,	ition furing most of we	orking	16b. Kind of Business/I	ndustry
121	within ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, Puncher)		Federal Go	
2	filed y Hygie ther i		1.2 17. Father's Name (First, Middle, Last)		жеу	runcher	19 Mothada Na	ano (Cimt Middle	e, Maiden Sumame)	veriment
and	d a b	Be	Luther Porter							
Z	should by	ပ	19a. Informant's Name/Relationship (Typ	no Print)	10h Maili	no Address (Canada	neste	r Jenki	ns	
, Maryland	d 2 s th ar 7 is		Corrinne Lawson	-Daughter				#112	per, City or Town, State, Z Capitol Hei	ghts, MD
ore	ages 1 and of Heall of Heall : If item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Re	20b	 Place of Dispo cemetery, crei 	osition (Name of matory or other place	9)	Date	20c. Location - City or 1	
Ē	9 5 E Z		'4 ☐ Donation 5 ☐ Other (Specify)	R1		e Park			Riverdale	•
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	teenan	1.	2. Name and Addres 353 H Str	s of Facility Ro eet, N	obert O E WDC	. Freeman F 20002	uneral Svc
1760,	Physician /Medical Examiner portion and privial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Social International and internationa	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):	Rothe Car	u) ioVAi	CUIAR	Disease	Onset and Death Y ROWS
.O. Box 68	the death certifica y the attending ph ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delik Month	rery Day Year
٥,	The law requires that ite has been signed b page 2 should be deta	by PI	Part II. Other significant conditions conf	tributing to death but not r	esulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use contribute to	the cause of death?
Vital Records,	v require been sig should b	edt	Cerebral In		<u> </u>			10	Yes 2 No 3 Pro	bably 4 □Unknown
000	law requas been 2 should	Completed	Penipheral Va	iscolar D	uses &			24a. Was		opsy findings available
Ä	The lav ate has page 2 :	Eo							psy prior to co ormed? death?	ompletion of cause of
ta		BeC	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only		2 No
>	iding Physicien: th. : After this certifica funeral director, I	0	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	-		idence 6 □Other (Speci	hu)
οL	ig Ph ter th	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	-	how injury occurred	"
<u>Ö</u>	Attending r death. sctor: After	atlo	1 Natural 5 Pending 2 Accident investigation	(monat, day rour)	Injury		es 2 🗆 No			
Division	of or Attendated after death I Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Special	home, farm, str cify)	eet, factory, office		28f. Location (City or To	Street and Number or Rur wn, State)	al Route Number,
	To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examin	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my op	e, date and place inion, death occi	e, and due to the urred at the time,	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
	To the hwithin 24 To the ficomplete	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Month,	Dey, Year)
}			1 Parch	Ou so	and	00	185	2 .	JANUARY ?	,2007
0	121		30. Name and address of person who con	npleted cause of death (It	em 23a) (Type.	Print)	7			
			PAUL A. DEVURE 31 Date filed (Month, Day Year)	32. Registrar's Sig	DUGG.	signizer Ro	d this	troville	TANUARY 3 MD 2078	7
ď	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2004	Street &	Local	es established				

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		and Mental H	lygiene Reg. No. 200	4 01397
	Physici /Medio			Roy				2. Date of Month	Ry 1 200	4 5:05P M
	Examir	er	4a. Facility Name (If not institution, give Doctor's Community 5. Social Security Number 6. Se	y Hospital	- e (In yrs. last birthday		anham			George's
X	Funeral Director		577-28-8127 Usual Residence of Decedent	XM 2□F	79 Yrs.	Months Day		Min. (Month,	Day, Yeer) 15, 1924	Birthplace (State or Foreign Country) Virginia
	h the Marylan r 28a-f show	irector	10a. State 10b. County Maryland Prince G 10e. Street and Number	George's	10c. City, Town or L				10g. Citizen of What	10d. Inside City Limits 1 □ Yes 2 □ No Country?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinational Percentilled at	Completed by Funeral Director	9203 Sheridan Sta 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13			gin? (Specify Yes or , Puerto Rican, etc.)	U.S.A. No- 14. Race - A Black, W Specify:	merican Indian, thite, etc. White
id 21215-0036	filed within 72 h Hygiene. other than "natu ent, the Madical	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last)	cation le completed) College (1-4or 5-	+) (Giv	edent's Usual Occ e kind of work don DO NOT use reti Glazer	ne during most red)		16b. Kind of Busine Walsh & I Glass & (Koehler
Maryland	should be and Mental smarked sumatic ev	To Be	Clarence E. Roy 19a. Informant's Name/Relationship (7)					r or Rural Route Nun	nber, City or Town, Stat	a, Zip Code)
\geq	s 1 and 2 f Health itam 27 other tra		Lorraine E. Roy — 20a. Method of Disposition 1 ABurial 2 Cremation 3 F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	lace)	et, Lanhar	20c. Location - City	or Town, State
Baltimore,	permit. Page Department o Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Service Licens		Arlington 4	22. Name and Add	fress of Facility	1/16/2004 Gasch's F	Arlington uneral Home attsville,	n, Virginia e, P.A.
8760, REPRESENTED	rate be executed whysician and hysician and hybridiansit the buriat-transit	sal Examiner	23a. Part henter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Angus) that initiated events resulting in death) Last	b. Due to (or as a	the death. Do not er	nter the mode of d	ying, such as o		arrest,	Approximate Interval Between Onset and Death Conset and Death Conset and Death Conset and Death
P.O. Box 6	es that the death certific igned by the attending p be detached for use as	t by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Petal death 3 time of death 5	□Ectopic pregnan □ Other (specify) underlying cause g	given in Part I.		23d. Date of Month d tobacco use contribute	Day Year
il Records,		Completed by	the 2	Sandy Co	T FA	MELL	tons	24a. Wa	as an 24b. Were prior topsy death	autopsy findings available o completion of cause of ?
ion of Vital	Hospital or Attending Physician: The 34 hours after death. Funeral Director: After this certificate tell filled in by the funeral director, page.	atlon: To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 patier 28a. Date of Injun (Month, Day		of 28c. Inj	Other: 4 🗆 Nur	28d. Describ	one sidence 6 □Other (S e how injury occurred	pecify)
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	i Certification:	3 Suicide 4 Homicide Could not be determined	building, etc.				City or T	(Street and Number or own, State)	
	To the Hospital or within 24 hours after to the Funeral Dit completely filled in	Medical	29a. Certifier (Check only one) 2	sician: To the best o ner: On the basis of and manner stat	examination and/or ii	vestigation, in my	time, date and opinion, death	I place, and due to the hoccurred at the time	e cause(s) and manner e, date and place, and d 29d. Date signed (Mc	ue to the cause(s)
R	6/14		30. Name and address of person who co	ompleted cause of de	path (Item 23a) (Type	, Print)	6197		January 1	
6.7	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 7 2004	32. Registra	r's Signature	es was	MADE	, pro	1070	ę

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jeffrey Peter Raybuck January 09, 2004 12:19 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 54 Edmundson Lane Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Pay, Year) 6/19/1971 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 32 222-64-4352 Delaware Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b, County Items 23s or 28s-f show the Medical Examiner must be notified at Clayton 1 ☐ Yes 2 No Delaware Kent Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1751 Alley Mill Road USA 19938 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other trainer." 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Distribution Elementary/Secondary (0-12) Coltege (1-4or 5+) Truck Mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kenneth Lee Raybuck Shirley Ann McMahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1751 Alley Mill Road Clayton DE 19938 Kenneth L. Raybuck/Father 20b. Place of Disposition (Name of competery, crematory, or other place)
Kent Cremation Service Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/11/2004 Smyrna, DE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Si milure of Poperal Service Lic as ee 22. Name and Address of Facility Faries Funeral Directors, Inc 29 S. Main St. Smyrna, DE 1997 MOOSIO Part Enter the disease, or complications that caused the death, shock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause Final disease or condition Physician CA resulting in death! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading 12 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled by the continued. burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the **IF FEMALE** 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[\] No 24a. Was an autopsy 2 No Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 XYes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Certification: To SCENE 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 10 2 Accident investigation the 1 6 Could not be determined Suicide 4 Homicide Location (Street and Number of City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. John pellij Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 10, 2004 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name -mp 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

2 1 2004

327 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For Stete Registrar	State of Ma		partment of H e <i>rtificate of l</i>			jiene _{eg. No} 2004	01399
ı	Physici		1. Decedent's Name (First, Middle, La Pauline Mae					2. Date of Dear Month Jan.		3. Time of Death 1:00 all.1
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give Lions Manor N 5. Social Security Number 215-26-6859	ursing Ho	Ome e (In yrs. last birthda 75 Yrs.	Cumbo	Location of Death erland If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/17/	4c. County of Dea Allega Year) 9. Bir Co	th NY thplace (State or Foreign buntry)
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		3/11/		10d. Inside City Limits
	f sho	ត្ត	MD Allega	ny	Cumbe	rland				1y∑Yes 2 ☐ No
	28a	Director	10e. Street and Number		1	10f. Zip Code		1	log. Citizen of What Co	ountry?
	N with	<u>=</u>	701 Furnace S	treet		2150	02		U.S.A	•
336	72 hours after death with the Maryland Insturel; or Items 23s or 28s-1 show disal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2CXNo	ispanic Origin? (Spe un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Constitu	
21215-0036	S - 4	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or t	(G life	cedent's Usual Occupive kind of work done on DO NOT use retired	ation during most of worki f)	ing	16b. Kind of Business Home	/Industry
	filed with Hygiene ther the	S	12			Olichaker	18. Mother's Name	/First Middle		
and	a a e	Be	17. Father's Name (First, Middle, Last S. H. ROOSEVE.		eman			s M. C		
Maryland	s 1 and 2 should be Health and Menta tem 27 is marked other traumatic ex	<u>٢</u>	19a. Informant's Name/Relationship (Gloria Turner/	Type, Print)	19b. M		and Number or Rura	I Route Number	r, City or Town, State,	
Baltimore,	0 0		20a. Method of Disposition 1 ABurial 2 Cremation 3 C 4 Donation 5 Other (Speci		cemetery, c	sposition (Name of rematory or other place Memoria	(e) 1/13	3/04	20c. Location - City or Keyser, W	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	n.L	ger	22. Name and Addres	d Funera	al Home	WV 2672	6
	Physician and // Medical Examine physician and physician and step physician and step physician and physician and step physician	al Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Alle v Due to (or as	ne.	enter the mode of dyin		0		Approximate Interval Between Onset and Death 3 months
O. Box 68760,	ath certi ttending or use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of de Month	livery Day Year
ds, P.O.	w requires that the de s been signed by the a s should be detached t	þ	Part II. Other significent conditions	contributing to death b			en in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
of Vital Records,	The law requate has been page 2 shou	Completed						24a. Was a autops perform	an 24b. Were a prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
ita	sian: ertificator,	Be (25. Was case referred to medical examiner?			704	26. Place of Death			
£	hysio this c	ို	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpati	ent 2 ER/Outpa		4 Mursing no		ence 6 Other (Spe	pcify)
	Attending For death. Sector; After by the funer	tion:	1 Natural 5 Pending 2 Accident investigation	(Month, Da		y Wor	k? Yes 2 □ No	200. 20001120 110	ow injury boodings	
Division	or Attenater deal	Certification:	3 Suicide 6 Could not l 4 Homicide determined	286. Place of III	ury - At home, farm, c. (Specity)	street, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying P (Check only one) 1 Medicel Exe	hysicien: To the best miner: On the basis o and manner st	f examination and/o	eath occurred at the tir r investigation, in my o	ne, date and place, pinion, death occurr	ed at the time, d	ause(s) and manner a date and place, and du	e to the cause(s)
)	To th Withir To th	Ž	29b. Signature and title of certifier Wowsorfe	Shu !	40	29c. Licens	55325		Jan 11, 2	th, Day, Year)
((de		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	00, Print) -8 MD 2	1532			
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 1 200	82. Regist	rar's Signature	8 MD 2				

			1 - For State Registrar	State of Maryland		artment of F rtificate of			giene Reg. No. 20	04 01400
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Las Albert Perry Robe 4a. Facility Name (If not institution, give	erson		4b. City, Town, c	or Location of Deat	2. Date of De Month Januar	Day Y	
٠,	Funeral Director		579-05-8404		ast birthday) Yrs.	Prince If Under 1 Year Months Days	Frederic If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da	Calvert (h, Year) 14,1917	County Birthplace (State or Foreign Country) Florida
	r 28a-f show	Irector	Usual Residence of Decedent 10a. State 10b. County VA Arlington 10e. Street and Number		, Town or Lo	cation 10f. Zip Code			10g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 🛣 No t Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event. If a Medical Evaluation trial be indiffied at ODGe.	by Funeral Director	2612 North 3rd St. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	reet 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		22201 Was Decedent of If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	U.S.A. 14. Race - Black, V	American Indian, White, etc. White
Maryland 21215-0036	a filed within 72 ho il Hygiene. other than "natur rent. Lra Medical	Be Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle, Last)	ucation de completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire E-Employe	during most of wo d)		16b. Kind of Busin Canvas Maiden Sumame)	ess/Industry Products
Marylar	d 2 should be th and Menta the marked treumatic ev	ToB	Thomas Roberson 19a. Informant's Name/Relationship (T) Richard P. Roberse			ng Address (Street Box 129,	and Number or Ri		er, City or Town, Sta	te, Zip Code)
Baltimore,	Pages 1 an ment of Heal ent: # Item 2 iury or other		20a. Method of Disposition 1 Shurial 2 ☐ Cremation 3 🔀 1 Other (Specify,	Removal from State Col	i ace of Dispo metery, cren umbia	sition (Name of natory or other place Gardens	Janu 20	ary 9,	20c. Location - City Arlington	, Virginia
Balt	permit Depart Import any in		21. Signature of the TS is is a second with the Signature of the disease, or comp	EC	81	L25 South	ern Mary	land Blv	d., Owing	Ivert, P.A. s, MD 20736
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a		tate	cance			Interval Between Onset and Death
8760,	cale be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	ence of)	Eothy R Syncop	oid			
P.O. Box 68	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetel 4 Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)	·		23d. Date of Month	delivery Day Year
Records, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions co	ntributing to death but not resul	ting in the ur	nderlying cause giv	en in Part I.		_	e to the cause of death?] Probably 4 2 Unknown
	in: The law inficate has b or, page 2 st	e Completed	25. Was case referred to medical				26 Place of Dec	24a. Was autop perfor 1 Yes	sy prior deat 2 No 1 🗆	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbole \text{No}\)
on of Vital	ding Physician: The I h. After this certificate ha funeral director, page	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	Hospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	R/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4⊠ Nursing H y at k?	lome 5 Resid	lence 6 Other (Sow injury occurred	Specify)
Division	or Atten ifter deat Sirector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre		Yes 2 □No	28f. Location (S City or Tow	Street and Number o. m, State)	r Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the d irred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To T	Z	29b. Signature and title of certifier D. SW	M. D.			9 number 50290		JANUARY	
	12		30. Name and address of person who con Dhiren Shah, M.I	o. 110 Hospita	al Roa	d, Suite	303, Pri	ince Fred	derick, M	20678
	Sta Registr	- 7	31. Date filed (Month, Day, Year) JAN 0	32. Registre's Signature 6 2003	the street	Sparke				

			1 _ For		State o	f Maryland				ealth and N	Mental Hyg	giene	2001	01101
			Registrar	- (P** A B B'-d-dt-	(4)		Ce	rtificate	Of L	Jeath		leg. No.	7 A A T	· UIAUI
	Physici	an	Decedent's Nam			_					2. Date of Dea Month	Day		3. Time of Death
	/Media	cal	4a Facility Name (Margue	erice give street and nu	Reus	sing	4h Chi T		Location of Dooth	January			12:20 A M
4	Examir	ier								Location of Death			County of Dea	ıtn
	Euporal		5. Social Security		y Nursing 6.Sex	7. Age (In yrs. Is	ast birthday)	If Under 1		rederick If Under 24 Hrs.	8. Date of Birth	1	alvert	thplace (State or Foreign
	Funeral Director		219-16-3		1□M ¾ □F	78		Months	Days	Hours Min.	(Month, Day March 9	, Year)	25 Mar	ountry)
	D.		Usual Residence of	of Decedent				1					20 11.012	7
	arylar show	_	10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 No
	8a-1	Sct	MD	Calve	ert	Lu	sby							
	with th	Ë	10e. Street and Nu					10f. Zip C			1	l0g. Citiz	zen of What C	ountry?
	es 236	era	11280 Mi	II Bric		edent Ever in U.S	10		657	onnoin Orinina /Bo			ted St	
	ter d	Funeral Director	11. Marital Status	ried 2□ Marri	Armed Fo	rces?	3. 13.	If Yes, specif	y Cubar	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		Black, Whi	
936	ours after death with the Marylan ref', or Items 23a or 28a-1 show Examiner must be notified at		3		If Yes, Giv Year or D	/e		1 ☐ Yes 2	No.	Specify:			Specify: Wh	ite
9	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show to Marical Exemiter must be nutting a	Completed by	/Sna	15. Decedent	s Education t grade completed)		16a. Dece	dent's Usual	Occupa	ition	ina	16b. Kir	nd of Business	/Industry
2	be filed within 72 hortal Hygiene. id other then "netunevent, Ire Maxical	nple	Elementary/Sec		College (-4or 5+)	life.	DO NOT use	retired)	uring most of work	"'g			
12	e filed within al Hygiene. I other then " vent, Ire Me		12	/Fi 14:			Homer	naker					Home_	
Maryland 21215-0036		Be	17. Father's Name David S		.ast)					18. Mother's Nam			Sumame)	
Z	d 2 should be th and Menta the marked traumatic ever	ဥ	19a, Informant's N		in (Tyne Print)		19h Mailir	an Address /	Stroot a	nd Number or Run	an R. Be		Tour State	Zin Codol
Ma	12 s h ar 7 ls trau		Michael							cidge Rd.				
ē,	s 1 and 2 of Health item 27 I		20a. Method of Dis		(1000)	20b. Pl	ace of Dispo	sition (Name	of				cation - City or	
Ê	Pages nent of I nnt: If it		1X Burial 2 `4 □ Donation		3 □Removal from ecify)	State	-	matory or oth		″ Ty Jan.8,	2004	21en	Burni	e MD
Baltimore,	arth orte inju		21. Signatury of Fi		icyng e					s of Facility Ra				
ä	Depar Impo		X	-Cito	MO 1	095								c, MD 20676
			23a. Part1. Enter	the disease, or	complications that o	aused the death	. Do not ent	er the mode	of dying	, such as cardiac	or respiratory arre	e <i>s</i> t,		Approximate Interval Between
	Physician	2 11	Immediate Cause disease or condition	(Final				AT10						Onset and Death
	/Medical Examiner		resulting in death)		Due to	or as a consequ	ence of):							1
	=xa::::::o:	_	Sequentially list co	onditions,	b. — Due to	DEPR or as a consequ	ESS	(00						month
	nsit	를	Cause (Disease or	r injury	Due to	or as a consequ	erice or,							
	execun n and ial-tra	Examiner	that initiated event resulting in death)	s Last	cDue to	or as a consequ	ence of):							
68760,	cate be executed physician and the burial-transit	dlcal			d									
-		led	15.55											
Box	in use as	an/N	IF FEMALE: 23b. Was deceder			come of pregnan		Ectopic preg	nancv			2	3d. Date of de	
	at the death by the attended for	Physician/Me	in the past 12	□ 1 66		ant at time of de		Other (spec					Month	Day Year
P.0	that th	P.	9 Unknown		ns contributing to de	anth but not room	Iting in the u	adarbijaa aau		n in Dort I	220 Did tob		a contribute to	the cause of death?
of Vital Records,	9 20	d b	HTY		EUMAT	~		RIT (5		iliii Faiti.		s 2		robably 4 Unknown
Ö	w requir been si should I	etec					100	1						
Rec	The lav ate has page 2:	Completed									24a. Was au autops perform	У	prior to death?	itopsy findings available completion of cause of
<u>a</u>		e Co	25. Was case refer	rred to medical						no Diana at Daniel		2 No		2 🗆 No
⋝	Physicien: this certific ral director,	OB	examiner?		Hospital:	npatient 2 🗆 E	R/Outnation	t 3 DOA	Other	26. Place of Death			□Other (See	aifu)
jo r		-	27. Manner of Dea	th	28a. Date		28b. Time of		. Injury Work		28d. Describe ho			City)
jo	_ = -	atlo	12 ☑ Natural 2 ☐ Accident	5 Pending investig	ation	n, bay rour)	плагу	М		es 2 □No				
Division		Certification;	3 ☐ Suicide 4 ☐ Homicide	6 □ Could n determi	ned 286. Place	of Injury - At hor	ne, farm, str	eet, factory, o	office		28f. Location (Sti City or Town		Number or Ru	ıral Route Number,
Ω	urs af ral D			/-						(1)				
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one)	2 Medical E	Physician: To the xaminer: On the ba	best of my know asis of examination ner stated.	vledge, death on and/or inv	occurred at restigation, in	the time my opi	e, date and place, inion, death occurr	and due to the ca ed at the time, da	iuse(s) a ate and p	and manner as place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and	title of certifier	->/			29c. L	icense	number	25	9d. Date	signed (Monta	h, Day, Year)
	->-0				5			I	31	6969		Janu	ary 5,	2004
	,		30. Name and add	ress of person v	no completed caus	e of death (Item	23a) (Type,						J J	2001
	6				M.D. 119			nan Rd	. Lu	ısby, Mar	yland 20	0657		
	Sta		31. Date filed (Mor	oth, Day, Year)	0 7 2003	egistra s Signatu	ure K	Lan	000					
	Registr	वा		W1111	9 4 4003	per peus	1 10.	10/104	- Charles					

			For State Registrar	State of Marylan		artment of H tificate of L		ind M	F	Reg. No. 2	004	01402
	Physicia	an	Decedent's Name (First, Middle, La	Judith Ann S	mith				2. Date of Dea Month January	Day	Yeer 104	3. Time of Death
	/Medic		4a. Fecility Name (If not institution, given		III CII	4b. City, Town, or	Location of		Januar y		ty of Death	5:39 A. ™
	LAGITITI	Ŭ.	3027 Traymore La	ine		Bowie				Princ		
c	Funeral Director		363-40-7919	5ex 7. Age (In yrs. 1 1 ★ 2 ☐ F 64	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birtl (Month, Day Jan. 1	v, Year)	9. Birth Cou Mic	ptace (State or Foreign intry) nigan
į	yland		Usual Residence of Decedent 10a. State 10b. County	_	y, Town or Lo	cation						10d. Inside City Limits
:	Ba-f s	ctor		Georges	Bowi							1 🖾 Yes 2 □ No
;	a or 2	Funeral Director	10e. Street and Number 3027 Traymore I	ano		10f. Zip Code	20715			10g. Citizen of USA		intry?
	ms 23	eral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.)	Was Decedent of Hi f Yes, specify Cuba			cify Yes or No-		ace - Amer	ican Indian,
036	be filed within /2 nouts atter death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	1	1 Yes, specify Cuba 1 ☐ Yes 2 🖾 No		, Pueno r	rican, etc.)		ack, White ify: Whi	
2-0	72 ho 'natur	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a Deced	dent's Usual Occupa kind of work done of DO NOT use retired,	ation during most	of working	ng	16b. Kind of	Business/I	ndustry
121	within than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, ical secre				Medio	~a1	
ם ס		Be Co	17. Father's Name (First, Middle, Las	1)		3001		r's Name	(First, Middle,			
/lan		To B	J	ames E. Macey			Do	orotł	ny Clar	k		
Š	# # # B	1	19a. Informant's Name/Relationship Charles W. Smith		1	ng Address <i>(Street a</i> Traymore						p Code)
ω .	of Head		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐		lace of Dispo emetery, crer	sition (Name of matory or other place	θ)	D	ate	20c. Location	- City or T	own, State
Ĕ	Pages tment of I tant: If it		* 4 □ Donation 5 □ Other (Speci	Md.		ans Cemete	_			Chelter		Md.
Bal	permit. Pages Department of Important: if it any injury or c		21. Signature of Funeral Service Lice	Reall		Name and Addres N.W.			eall Fu			15
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death							. 207.	Approximate Interval Between
98	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent	uence of):	Carlo	1					Onset and Death
760,	ate be executed hysician and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	c. Due to (or as a consequence of the consequence o	uence of):	ne						
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)					ate of deliving	very Day Year
ds, P	lures that n signed b	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			bacco use cor		the cause of death?
Records,	he law require e has been si ige 2 should b	Completed							24a. Was a autop perfor	med3	prior to co death?	opsy findings available ompletion of cause of
ta	an: T tificat tor, pa	Be Co	25. Was case referred to medical				26. Place	of Death	1 ☐ Yes (Check only-or		1 🗆 Yes	2□ No
>	Physician: The la r this certificate had ral director, page 2	To E	examiner? 1 ☐ Yes 2 ☑ No		ER/Outpatier		4 U Nur	rsing Hom	ne 5 Resid	ence 6 🗆 O1	ther (Speci	fy)
Division of Vital	ing Afte une		27. Mann Peath 1 Atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury	Work	rat ⟨? Yes 2 □ N		8d. Describe h	ow injury occu	urred	
Divis	in Direct	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ome, farm, str y)	eet, factory, office		2	8f. Location (S City or Tow	itreet and Num n, State)	nber or Aur	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina /and manner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	ne, date and pinion, deat	d place, a h occurre	nd due to the o	cause(s) and n date and place	nanner as : , and due !	stated. to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	21		29c. License	number		2	29d. Date sign	ed (Month,	Day, Year)
)			· Carle	tarn M	0	1)3	733	06		//	8/01	
)	(10)	- 3	30. Name and address of person who	mpleted cause of death (Item	1 23а) (Туре,	Print)	1 4	1	,		,	m02140
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	5.55	nestgat	PR	1 5	to 211	Ann ap	1015	11/12/40
	Sta Registr		JAN 0 9 2004	Recent . K	book							

	乘	For Amend Item 24a Registrar 1. Decedent's Name (First, Middle, Last			incate of	Dealii	2. Date of Dea	ith	3. Time of Death
Physici /Medic Examir	al	JOSEPH GJ 4a. Fecility Name (If not institution, give	LESSON street and number)	SAI	VDERS 4b. City, Town,	or Location of De	JANUAR eath	Day Yee Y 7 2004 4c. County of De	1 12:30p
Funeral		FREDERICK MEMOR 5. Social Security Number 6. Se 215-03-3363		last birthday) Yrs.	FRED If Under 1 Year Months Days		lin. (Month, Day		ICK Birthplece (State or Foreig Country) IRFIELD, PA.
	Director	Usual Residence of Decedent 10a. State 10b. County PA ADAMS	10c. Ci	ty, Town or Lo	VALLEY			10g. Citizen of What	10d. Inside City Limi 1 🖾 Yes 2 🗆 N
23a or 2		10e. Street and Number 8 PALOMINO TRAI	L		10f. Zip Code 1732	0		U.S.A.	Country
iene. than "natural", or Nema 23a or 28a-f show tha Medical Examiner must be multified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 41-4		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🛣 No		(Specify Yes or No- erto Rican, etc.)	14. Race - Al Black, W Specify: W	
ne. han "natura a Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of v	working	16b. Kind of Busine	
ental Hyg ked othe Ic svant,	To Be Co	8 17. Father's Name (First, Middle, Last) SAMUEL H.	SANDERS		STITCHER		Name (First, Middle, HERINE BEA	Maiden Sumame)	OTOKI
T Is m traum	9	19a. Informant's Name/Relationship (7) CYNTHIA S. MALLET		1	-			r, City or Town, State	
nt of Health I: If Item 27 I r or other tre		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other pla	ace)	Date	20c. Location - City	
Department Important: any injury o		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licen		22	. Name and Addr	ess of Facility	SKILES F	UNERAL HON	ME
ysician Medical kaminer	Iner	if any, leading to immediate cause. Enter Underlying	ications that caused the deal ne cause on each lipe. a. Due to (or as a consection)	quence of):	er the mode of dy	ing, such as carc	diac or respiratory am	rest,	Approximate Interval Between Onset and Death
cian and ourial-trae	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):					
by the attending physi tached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a 9 □ Unknown	al death 3	Ectopic pregnand Other (specify)	су		23d. Date of o	delivery Day Year
been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause g	iven in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
ate has	Completed	anemi	Z-				24a. Was a autop: perfor 1 \(\triangle \trian	sy prior t mad? death	autopsy findings availal to completion of cause of ? les 2 \(\text{No} \)
within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 DX6 27. Manner of Death 1 DXatural 5 Pending	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		her: 4 Nursing		ne) ence 6 Other (Si ow injury occurred	ресіfу)
after death. Director: Af I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci			Yes 2□No	28f. Location (S City or Town		Rural Route Number,
within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exam	sician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death ation and/or in	h occurred at the I vestigation, in my	ime, date and pla opinion, death of	ace, and due to the c ccurred at the time, d	ause(s) and manner date and place, and d	as stated. lue to the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier	Eller	elm.	29c. Licer	se number	96	29d. Date signed (Mo	2004
		30. Name and address of person who c	ompleted cause of death (ite	m 23a) (Type,	Print)		St. Fre		m/21701

Physici		Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate of	Death	2. Date of De		3. Time of	Death
/Medic		BETTY	C.	STREETER	2			JAN.	2, 200	Yeer 04:30	P 1
Examir		4a. Fecility Name (If not institution,	give street and num	ber)		4b. City, Town, o	or Location of De	ath	4c. County o	f Death	
•		SHADY GROVE A					VILLE			IGOMERY	
neral ector		5. Social Security Number 216-40-5716 Usual Residence of Decedent	3. Sex 1 ☐ M 2 K F	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	n. (Month, Da	th ly, Year) 1, 1939	9. Birthplace (State of Country) VIRGINIA	
10		10a. State 10b. County		10c. City, To	own or Loc	ation				10d. Inside C	ity Limit
Illed	ctor	MD. MONTG	OMERY		(GAITHERS1	BURG			X Yes	2 🗆 N
any injury or other traumatic event, the Madical Examinar must be notified at poce.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?	
Inst	ral		PHER AVE.		1	208				S.A.	
	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For		13. W	As Decedent of H Yes, specify Cuba	dispanic Origin? an, Mexican, Pu	(Specify Yes or No arto Rican, etc.)		 American Indian, White, etc. 	
	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Da	•	1	☐ Yes X No	Specify:		Specity:	WHITE	
	Completed	15. Decedent's (Specify only highest		10	6a. Deced	ent's Usual Occup	ation	makina	16b. Kind of Busi		
	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. D	O NOT use retired	d)	TOTKING			
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	Be	17. Father's Name (First, Middle, La		NTC.			18. Mothers N	ame (First, Middle,			
	2	CHARLE 19a. Informant's Name/Relationship		NES	Igh Mailing	Address /Street	and Number or	ELSIE I		RRESS	
		LOUIS A. STREE			13520			MT. AIR			
5		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of		Date Date	20c. Location - C		
		1 ☐ Burial 3X ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		Rate		CREMATOR		-2004	DIVEDI	MTE MD	
9		21. Signature of Funeral Service Lie		CHAP	22.	Name and Addre	ss of Facility	Consession		DALE, MD.	
any i		W.W.CH	anvey	M0009	1 58	O1 CLEVE	ELAND AV	HOME & CI	REMATURIU RDALE, MI	DM, P.A. D. 20737	
ical ner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	or as a consequence							
	cal	that initiated events resulting in death) Last	Due to (d	r as a consequenc	ce of):						
	cal	that initiated events	d	ome of pregnancy th 2 ☐ Fetal dea nt at time of death	ath 3⊡E	Ectopic pregnancy Other (specify)	,		23d. Date Month		/ear
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition: 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could not determine 4 Homicide 29a. Certifier (Check only one) IMPORTANTIAL STATEMENT OF THE COULD COULD THE COULD TH	d	ome of pregnancy th 2 Fetal dea th at time of death wn ath but not resulting patient 2 EP/ Injury Day Year of Injury - At home, g, etc. (Specify)	ath 3 dispersion of the unit o	Other (specify) derlying cause give 3 DOA 28c. Injun Work M 1 1 et, factory, office occurred at the timestigation, in my office 29c. License	26. Place of D er: 4 Nursing y at k? Yes 2 No	24a. Was a autop performed at the time.	Month bbacco use contrib fes 2 No 3 an 24b. We prive dea 220 No 1 Control lence 6 Other now injury occurred Street and Number m. State)	ute to the cause of d Probably 4XIL ere autopsy findings a for to completion of ca ath? Yes 2 \(\sum \) No (Specify) or Rural Route Num. ther as stated. d due to the cause(s)	Bath? Jinknowi available ause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2004 Month 10 **Physician** Tansbur ENE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. Zens Home ursing le Grace tar 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕽 F Vrs Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exput April Trust be rediffied at once. 1 ☐ Yes 2 No Completed by Funeral Director Marxland 10g. Citizen of What Country? 10f. Zip Code 2100 Was Decedent Ever in U.S. Armed Forcas?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced ac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker Come 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanchury Bolsonwood Terrace Nephen qurel Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Union United Methodict Church 27 Name and Address of Facility Funera 21. Signature of Funeral Service Licensee Home Aberdeen 21001 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner extou crox Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner rdio vascular disease To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Completed by Physiclan/Medical use as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 DNo 3 Probably 4 Unknown tansbury, Mabe has been 24a. Was an autopsy pertormed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 2 No certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred 28b. Time of After Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print) 1 200422. Régistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Hac

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Phýsician January 11, Nathaniel Wilson Schley, Jr. 10:17 PMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 408 West Second Street Frederick Frederick 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer) 6. Sex 1 M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director Yrs 216-22-9975 10, 1928 Maryland Usuel Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Exempler must be notified at 1 Yes 2 □ No Maryland Frederick Frederick Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 408 West Second Street 21701 12. Was Decedent Ever in U.S. Amed Forces?

1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1951–53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Subrogation Manager Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental int: if Item 27 is marked o and Mental Nathaniel Wilson Schley Mary Margaret Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Celeste Schley, wife 408 West Second Street, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 1/14/2003 Frederick, Maryland 22. Name and Address of Facility
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21. Signature of Funeral Service Licenses M00999 Recitey and Dastord PA Funer 106 East Church St., Freder 106 eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CX6- Ensive Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Examiner Due to (or as a consecuaring of) The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 25 No certificate 1□ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home Residence 6 | Other (Specify) 2 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 12, 2004 D 146 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) 1 2001 32. Resistrar's Signature 50 MB Registrar

Dharai		1. Decedent's Name (First, Middle, La				2. Date of Death Month	Day Year	3. Time of Death
Physici /Medi		PATRICIA ANN	SCHWAB			JAN.12		2:30P
Exami	and the same	4a. Facility Name (If not institution, give		4b. C	ity, Town, or Location of Dea	th	4c. County of Deeth	
		12599 SUBSTATI		last hirthdays If I In	WALDORF der 1 Year If Under 24 Hrs	S Date of Birth	CHAR]	
Funeral Director			Sex 7. Age (In yrs.	50 Yrs. Mont			,1953 P	place (Stete or Fore ntry) A •
Mo to		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Lim
it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Musical Examinar must be notified at	tor	MARYLAND CHA	RLES		WALDORF			1 □ Yes 2√2
or 28	Director	10e. Street and Number	_	10f.	Zip Code	109	g. Citizen of What Cou	ntry?
23a	ral	12599 SUBSTATI			20601		U.S.A.	and the state of
items	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De	scedent of Hispanic Origin? (specify Cuban, Mexican, Pue	to Rican, etc.)	14. Race - Ameri Black, White,	
l, or	by F	1 ☐ Never Married 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 □ Ye	s 2∰ No Specify:		Specify:	WHITE
atura sal E		15. Decedent's E	ducation	16a. Decedent's U	Jsual Occupation work done during most of wo	16	6b. Kind of Business/In	ndustry
than 'n	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life. DO NO	T use retired)	orking		
Hygiene.	Completed	12		BUS D			ELLER BU	s co.
d other	Be	17. Father's Name (First, Middle, Las				me (First, Middle, Ma		
Mental Parked o	၉	CARLTON LAV		405 14-11- 444		LENE KUH		Codel
h and 7 is m traum		19a. Informant's Name/Relationship			ress (Street and Number or F		LDORF, MD	
Health tem 27		STEVEN SCHWAB- 20a, Method of Disposition	20b.	Place of Disposition (SUBSTATION Name of		Oc. Location - City or To	
Hit is		1 ☐ Burial 2 TCremation 3		cemetery, crematory`	or other place) CREMATORY 1			
Department of Important: If i any injury or once.		`4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice			and Address of Facility	-14-04 A	LEXANDEL	A, VINGI
Depa Impo any ir		m	0	// RA	YMOND FUNER	AL SERVI	CE,P.A.	
===		23a. Part1. Enter the disease, or cor	nplications that caused the dea		PLATA, MARY mode of dying, such as cardia			Approximate
		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		RT DISEASE			Interval Between Onset and Deat
hysician Medical		disease or condition resulting in death)	a. Due to (or as a conse		KI DISEASE			
xaminer				ERTENSIO	N			
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):				·
ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	DIA	BETES ME	LLITUS TYPE	II		
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hysic the bi	Ilcai		d					
attending physical for use as the t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	anow.			2212111	
attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet	el death 3 DEctop	ic pregnancy		23d. Date of deliv Month	ery Day Year
the bed	ysic	1 ☐ Yes 2 ☐ No 9 X Unknown	9 Unknown	3 0 0 0 0 0	(specify)			
igned by be detac	P.	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyi	ng cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death
een signed b tould be deta	d by					1 ☐ Yes	2 No 3 Prol	bably 4 Munkm
Q 70	lete					24a. Was an	24b. Were auto	opsy findings avail
ate has page 2	Completed					autopsy	prior to co death?	empletion of cause
certificate rector, pag	ပိ	25. Was case referred to medical			26 Place of De	1 Yes 20 eath (Check only one)	S No 1 ☐ Yes	2 No
	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Othor	1104	ice 6 □Other (Specia	fy)
	P:u	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Pescribe how		
r death. ector: After by the funer	atlo	1 Accident 5 Pending 2 Accident investigati	on	,у	1 ☐ Yes 2 ☐ No			
	Certification;	3 Suicide 6 Could not determine		nome, farm, street, fai	ctory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
within 24 hours after of the Funeral Direct completely filled in by	Cer							
uneral f			hysician: To the best of my kn eminer: On the basis of examin					
in 24 the F	Medical	one)	and manner stated.					
To b	12	29b. Signature and title of certifier			29c. License number		d. Date signed (Month,	
11/		Julia.	11 Tajawi		De05080))	L. 14.04	
W/		30. Name and address of person who			0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Certificate of	Death	Reg. No. 2004	01408
Physic /Med Exam	lical	Decedent's Name (First, Middle, Last) Statement (Statement) Statement (Statement) Aa. Facility Name (If not institution, give statement)	treet and number)	SKin 4b. City, Town, o	Mont	of Death th Day Year JUCK D 2015 4c. County of Deat	
Funera Directo		5. Social Security Number 231-33-3672 Usual Residence of Decedent	HOPKINS HOS 7. Age (In yrs. last) 22	Orthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date (Moni Apr.	th, Day, Year) Co	hplace (State or Foreign untry) rginia
Maryland -f ehow	tor	10a. State 10b. County Virginia Fauquier	10c. City, To Warren	own or Location			10d. Inside City Limits 1 Yes 20 No
th with the 23s or 28s	al Director	10e. Street and Number 6712 Kelly Road		10f. Zip Code 2018	37	10g. Citizen of What Co	untry?
ILK ID-UUSO within 72 hours after death with the Maryland ene. than "naturat", or itams 23a or 28a-f show than Medical Examiner must be notified at	by Funeral	11. Marital Status 153/Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et Specify:	or No- c.) 14. Race - Ame Black, White Specify: White	e, etc.
DENTITIONEY, MISTYIERIG ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, tha Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		ia. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired homemaker	ation during most of working t)	16b. Kind of Business/	Industry
Maryland 4 2 should be filed th and Mental Hyg 7 is merked other	To Be C	17. Father's Name (First, Middle, Last) Arthur E. Clevenge	er		18. Mother's Name (First, M	Middle, Maiden Sumame) Baldwi	ln
ind 2 shou aith and N 27 is ma		19a. Informant's Name/Relationship (Ty) Theresa Skinner / n			and Number or Rural Route No., Warrenton V.	Number, City or Town, State, 2 A 20187	(ip Code)
Dallimore, Dermit. Pages 1 au Department of Hea Mportent: If item any injury or othe		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	of Disposition (Name of tery, crematory or other plac wall Memory	Gardens 1/17/0	20c. Location - City or D4 Manassas,	
Darrit. Departminimporte any injury		21. Signature of Funeral Service License		22. Name and Addre	ss of Facility	233 Broadview • Warrenton, V	Ave.
Physician /Medica Examiner	1	23a. Part 1. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of the consequence)	stma cal Ed	M Dic		Approximate Interval Between Onset and Death Compon+NS
death certificate be executed death certificate be executed at attending physician and d for use as the burial-transit	Medical	in the past 12 months?	Due to (or as a consequence) 3c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal dea} \) 4 \(\subseteq \text{Pregnant at time of death} \)			23d. Date of delif	very Day Year
d by the letached	d by Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions con	9□ Unknown			Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ Pro	the cause of death?
	Completed					autopsy prior to c performed? death?	topsy findings available ompletion of cause of
Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1x Inpatient 2 EP/0	Outpatient 3 DOA Oth	26. Place of Death (Check of		
Attending Physic death. ector: Atter this by the funeral di	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	. Time of 28c. Injury Work		Residence 6 Other (Spec cribe how injury occurred	ny)
ospitel or Attending hours after death. unerel Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		tion (Street and Number or Rui or Town, State)	ral Route Number,
To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one)	ician: To the best of my knowledger: On the basis of examination a and manner stated.	ind/or investigation, in my of	pinion, death occurred at the t	time, date and place, and due	to the cause(s)
With Ton Con	2	29b. Signature and title of certifier		29c. Licenso	46058	JANUARY II	
		30. Name and address of person who co. ANISH BHALTWAT		WOLFE ST	FEET, BALTI	MORE, MD 2	12-87

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			For State Registrar	1100001	State of Ma	aryland		nent of F		and Me		giene Reg. No.2	004	01409
			1. Decedent's Name (i	First, Middle, Last)	1						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Gertrude	Go	lden	Smith	1				01	060	04	3.00 P.M
1	Examin		4a. Fecility Name (If no	ot institution, give :	street and number)	1	4b.	City, Town, o				_ ^	nty of Death	
			SACrec	MEAR		DITAL			erlf		0. 0		LeG	
- 6	Funeral		5. Social Security Num	. 1	144	(In yrs. last		Inder 1 Year onths Days	If Under a	Min.	8. Date of Bir Mar 8,	1 1 9 4	9. Birth	plece (Stalte or Foreign (Ny)
Ł	Director		214-05-533 Usual Residence of De)9	™ ₩□	,					widi o,			
	and and			0b. County			own or Locatio				-	,		10d. Inside City Limits
	Mary Ind	to	MD	Allegany		F	rostbur	9						X□Yes 2□No
	r 28e	irec	10e. Street and Numb	er			11	Of, Zip Code				10g. Citizen		intry?
	4 within 72 hours after deeth with the Maryland jiene. Than "natural", or tleme 23e or 28e-f ehow the Medical Evans are must be notified at	by Funeral Director	48 Tarn Te	errace				2	1532			U	SA	
	dee	ner	11. Marital Status		12. Was Decedent B Armed Forces?	ver in U.S.	13. Was	Decedent of H s, specify Cuba	lispanic Orig	gin? (Spec	cify Yes or No lican, etc.))- 14. F	Race - Ameri Black, White	
92	or it	y Fu	1 Never Married		1 ☐ Yes 2 ☐ N If Yes, Give	lo		es Z No	Specify:				citywhite	
8	ural'.	Q P	¥□Widowed 4 [Year or Dates:		6a. Decedent's	. Havel Occur	ation				f Business/Ir	
15	n 72	lete	(Specify	5. Decedent's Edu only highest grade	e completed)		(Give kind life. DO N	of work done of OT use retired	during most	of workin	g	160. Kind o	i Boşiliê22/ii	loustry
12	withi ene. then	Completed	Elementary/Second	ary (0-12)	College (1-4or 5	+) ho	memak					wn ho	me	
9	Hyg tha		17. Father's Name (Fin	rst, Middle, Last)								Maiden Surr		
lan	id be ked ked	To Be	George	O. Schriv	er				Gert	rude	Wiebe	el Golde	en	
Maryland 21215-0036	de mu		19a. Informant's Nam			1	19b. Mailing Ad	Idress (Street	and Numbe	r or Aural	Route Numb	er, City or To	wn, State, Zij	10°21502
	1 and 2 Heelth a em 27 la		Betty Buja	C	friend		909 LOI	ıısıana	Avenu	Je	Cumb	enanu		710 21302
Baltimore,	of Heeli of Heeli litem 2		20a. Method of Dispos		lemoval from State	20b. Place ceme	of Disposition etery, cremator	(Name of y or other place	(e		ate 7/2004		on - City or T	
E	permit. Peges Department of the find portant: If Ite any injury or of once.		`4 □ Donation 5		ternoval from State	Scarpe	elli Funera	al Home,	P.A.	1/	7/2004	Cresa	ptown	MD
alti	permit. Pe Departmen Important: any injury once.		21. Signature of Fune	ral Service Licens	pe /	0 .	22. Na	Scarpelli	*Fuhera	ăl Hon	ne, PA			
<u>m</u>	Deprimed fimbers for the period of the perio		(rov	ms t	Jesp	lu'		108 Virgi	nia Ave	enue: (Cumberl	and, MD	21502	
	- 1-		23a. Part1. Enter the shock, or heart f	disease, or compli ailure. List only or	ications that caused ne cause on each lin	the death. E	Do not enter the	e mode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition		sepsi		syndr							Onset and Death
lagi	/Medical		resulting in death)		Due to (or as		ce of):							
	Examiner		Sequentially list condi	tions,	Bilat		_	moni	ia					
	De is	Examiner	Sequentially list condi- if any, leading to immi- cause. Enter Underly Cause (Disease or inju-	ediate ing	Due to (or as	a consequen	ce of):							
	and and I-tran	хап	that initiated events resulting in death) Las		Due to (or as	a consequen	ce of):							
760,	ate be executed hysician and he burial-transit	cai E			540 10 (01 40 1	2 001.00400	00 0.7.							
687	physic the				d									
×	eath certificate attending phy for use as the	Physiclan/Med	IF FEMALE:	2	3c. If yes, outcome	of pregnancy						23d	Date of deliv	erv
Вох	atten for u	clan	in the past 12 mg	onths?	1☐Live birth 4☐Pregnant at	2 Fetal de	ath 3□Ecto	pic pregnancy er (specify)					Month	Day Year
P.O.	at the de by the a	iysi	1 ☐ Yes 2 🔼 N 9 ☐ Unknown	10	9□ Unknown									
	de de		Part II. Other significa	nt conditions cor	ntributing to death bu	ıt not resultin	g in the under	ying cause giv	en in Part I.		23e. Did t	obacco use c	ontribute to t	he cause of death?
Records,	quires n sign	d by									1 🗆 '	Yes 2□No	3 ☐ Prof	bably 4 Unknown
00	w require been sign	lete									24a. Was			opsy findings available
Be	The lavate has	Completed										rmed?	death?	mpletion of cause of
Vital		0	25. Was case referred	I to medical					26. Place	of Death	1 Yes		1 163	24(110
<u>></u>	ysicia is cer direct	0 B	examiner? 1 ☐ Yes 2 X No	,	lospital: 1 XInpatie	nt 2□ER/	Outpatient 3	□ DOA Oth	or			dence 6 🗆 0	Other (Special	fy)
o t	g Ph er thi	n:	27. Manner of Death		28a. Date of Injur (Month, Day	y 281	b. Time of Injury	28c. Injun Wor	y at			now injury occ		
Ö	uttendin death. ctor: Aft y the fun	atio	2 Accident	5 Pending investigation	(13.03.1.1, 0.03)	, 54.7	N,GI,		Yes 2□N	No				
Division	ol or Attending P safter death. I Director: After t d in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju-		, farm, street, f	actory, office		28	8f. Location (mber or Aun	al Route Number,
Ö	tel or A	Cer												
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2[Certifying Phys	sician: To the best oner: On the basis of	avamination	and/or invacto	ation in my o	ninion dont	h cocurre	d at the time	data and nice	manner as s	stated. o the cause(s)
	To the H within 24 To the F complete	Medical	one)		and manner sta	ted.		200 1				20d Dat		
	vitt To	2	29b. Signature and titl		2/	un		D O o Z	- p- 2 -	-		29d. Date sig		
				socks	in !	11)		D006	552	ン		Janc	7,20	704
	i)		30. Name and address		mpleted cause of de	eath (Item 23	a) (Type, Print		c Hair	172 B	10011	5 30		·
			WONSOC		A Registra	r's Signature	· CVVIII	e Pro	1100	7	-02-13	102		
	Sta Registr		31. Date filed (Month, JAN	2 1 2004	and manner sta	d	Sperte	,						

State of Maryland / Department of Health and Mental Hygiene

					Otato of N	iai yiai		•		Death	Wichtai II	Reg. No. 2	101.	011.1	
			1. Decedent's Name (First, Mic	idle, La						-	2. Dete of D	eeth	S. S. S. Bady	3. Time of Death	0
	Physicia /Medic		Barbara		Stee	10					Jan	O4	Year 2.004	1325	-
	Examin		4e Fecility Neme (If not institut) /				4b. City, Town, or	Location of Dea		ran		
			Deer's Head	HOS	pital Cer	utes				Salish	bury.	WI	conn	20	
	Funeral		5. Social Security Number	6. S	ex 7.A □M 2DXTF	ge (In yrs.	last birtho	Month	der 1 Year is Days	If Under 24 Hr Hours Mir	s. 8. Date of B	irth Day, Year)	9. Birthp	lace (State or Foreig	<i>g</i> n
	Director		577-72-3115		DW ZĀ	51	Yrs	i.			9/27/	1952		DC	
	and §		Usuel Residence of Decedent 10a. Stete 10b. Coun	ity		10c. Ci	ty, Town o	r Location					1	0d. Inside City Limit	ls
	daryl 1 sho	5											1	1 ☐ Yes 2 ☒ N	
	the the property of the proper	Director	MD V 10e. Street end Number	Vico	mico			10f.	Sal Zip Code	isbury		10g. Citizen of	What Cour	trv?	_
	ith with the Marylar 23e or 28e-f show				Troppital	Dood				21802				,	
	me 2	Funeral	351 Deer's He	au	12. Wes Decedent	Ever in L	ı,S.	3. Wes De	cedent of I	dispanic Origin? (an, Mexican, Pue	Specify Yes or N		USA ce - Americ		_
0	after daa or fterne miner m		1 Never Married 2 M	erried	Armed Forces 1 ☐ Yes 2 🔀						rto Rican, etc.)	Bia	ck, White,	etc.	
8	ours a	۾	3 ☐ Widowed 4 🂢 Divorce	ed	If Yes, Give Year or Dates:			1 ⊔ Yes	2⊠ No	Specify:		Specif	r: Wh	ite	
Maryland 21215-0020	72 hours after daath with the Maryland natural', or Neme 23e or 28e-1 show deal Examinet must be notified at	Completed	15. Deced (Specify only high	ent's Ed	ucation de completed)		/G	ecedent's U	<i>work do</i> ne	during most of wo	orkina	16b. Kind of B	usiness/Inc	lustry	
2	within ana.	葿	Elementery/Secondary (0-12	_ i	College (1-4or	5+)	lif	e. DO NOT	use retire	d)					
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ű	S is S	mĭ l	17. Fether's Name (First, Middl	e, Lest)								e, Maiden Sumar	ne)		
ž	should be ind Mantal i marked o umatic eve	၉	Jack N.				405 14	-111 6-4-4	(С4		ith L.		0-1-7-	0.4.1	
Σa	d2 sl than 7 is r	ı	19a. Informant's Name/Relatio				7	_		and Number or F		•			
	s t an if Haal item 2	1	Mary F. Dunning 20a. Method of Disposition	g/S1	ster	20b. F	Place of Di	sposition (A	lame of	Ave., Pr	nce Fro	20c. Location			-
Baltimore,			1 Durial 2 Cremation			, '	cemetery, o	crematory o	r other pla						
Ħ	Demit. Pa Departmer mportant. any injury	ı	4 □ Donation 5 □ Other		-	Me	tropo			on of Engility				Virginia	-
Ba	permit. Page Department of Important: If any injury or once.		16/1	To						, Dunkir	_		eral	Home, P.A	7 •
		7	23a. Part1. Enter the disease, shock, or heart failure. Li	or comp	plications that cause	d the deat								Approximate Interval Between	
)	Physician				1. 4	4 1		7				- 4	i	Onset and Death	
1	/Medical Examiner		Immediate Cause (Final disease or condition		a flun	tingl	04'5	()15	pase	with 1	mogres	sive Den	nentia	154rs	
1		_	resulting in death)					sequence o		1				- 1	
	bed is	edical Examiner			b								ľ		
•	death certificata be executed e attending physician and ed for use as the burial-transit	Xa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Due to (d	or as a con	sequence o	f):						
68760,	siciar buni	<u> </u>	Cause (Disease or injury that initiated events	< −	C	D / -	Jul 9-311								
89	ficate p phy as the	ğ	resulting in death) Last	1		Due to (o	r as a cons	sequence o	r):				!		
Box		2			d										
œ.	death a atte d for	2	Part II. Other significant condi	tions co	entributing to death h	out not res	ulting in the	e underlying	rause div	ren in Pert i	23h Did	tohacco use co	ntributa to	the cause of death	n?
P.O.	t tha by the tache	Physician/							, g					abiy 4 □ Unknow	
	s tha	2													
of Vital Records,	v requiras that tha death cer been signed by the attendir should be datached for use	Completed										s an autopsy ormed?	ava con	re autopsy findings ilable prior to apletion of cause	
æ	2 5 8	틸									200			leath?	
ā	Physician: The I this certificata he ral director, page		25. Was case referred to medic	al						26 Plans of Do	ath (Check only	Yos 200 No	1]Yes 2□No	
>	Physician: rthis certific ral director,	0 26	examiner? 1 ☐ Yes _2 ☒ No	+	Hospital: 1 ☐ Inpatie	ent 2	ER/Outpat	tient 3 🗆 l	OCA Oth	er.	1.00	idence 6 □Oth	er (Specifi	1	
	ng Phy ter this neral		27. Manner of Death 1 ⊠ Naturel 5 □ Pend	lina	28a. Date of Inju		28b. Time Injur	e of	28c. Injur Wor		-	how injury occur		/	T
sio	Attending or death. sctor: After by the fune	Cac		tigation				М		Yes 2 □ No					
Division	or Att	Certification:		mined	28e. Plece of In building, et	ury - At he c. (Specif	ome, farm, V)	street, fact	ory, office			(Street and Numb wn, State)	er or Rural	Route Number,	
	ours cours filled	<u> </u>	29a. Certifier 1⊠ Certify	ina Phy	sician: To the best	of my kno	wledne de	ath occurre	d at the tin	ne date and place	and due to the	rause(s) and ma	nner se et	ated	
	To the Hospital or Attending Phys within 24 hours aftar death. To the Funeral Director: After this complataly filled in by tha funeral di	egica egica		l Exam	iner: On the basis o and manner st	f exemina	tion end/or	investigation	on, in my o	pinion, death occi	urred at the time,	date and place,	and due to	the cause(s)	į
	To the To the Comp		29b. Signeture and title of certif	ier				2	9c. Licens	e number		29d. Date signe	d (Month, [Day, Year)	
			M. Shro	sti	9 MD				00	16278		Jan 4 -	200	04	
	0		30. Name end eddress of perso	n who c	ompleted cause of c	leath (Iten	23e) (Typ	e, Print)			0	A . 1			
	4		WEER'S HEAD	MOS	PITAL CE	NTER	. JA.	LIS BL	Ry	P.O.Bo	2018.	19d 2	1802		
	Stat Registra	-	31. Dete filed (Month, Day, Yea	,	32. Registr	s Signe	ture	la	wer						
	negistia		UMI	* U	✓ /IUUJF &	OF ANGLISH	7 20	100							

DHMH 16 Rev 6/95

		= State Registrar Amend Item/7pe 1. Decedent's Name (First, Middle, Last)	rFHG828 2/21/04	EW Ce	rtificate	e of L)eatn	2	. Date of Deat	g. No.	C 4	3. Time of Death
Physici		Thomas Lewis Scar	selli						Month anuary		Year 1	8:34 A
/Medic		4a. Fecility Name (If not institution, give s		-	4b. City,	Town, or	Location of			4c. County of		
		10321 Three Doctors	Road			nkirl				Calve		
uneral irector		117-22-2810	7. Age (In yrs. 73 73 73 73 73 73 73 73 73 73 73 73 73		If Under Months	Days	Hours	0.01	Jan • 14	, 1930	9. Birthi Cour New	place (State or Fore http:// York
A to	}	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						1	IOd. Inside City Lim
finds	ţ	MD Calvert	Co. Du	ınkirk								1 □ Yes 2√
rai', or items 23a or 28a-f show Examinar must be natified at	I Director	10e. Street and Number 10321 Three Doctors	s Road		10f. Zip	Code 754	-		11	0g. Citizen of W	hat Cour	ntry?
rms 2	Funeral	11. Marital Status	Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Deced	lent of His	spanic Origi	in? (Speci	fy Yes or No-		- Americ	can Indian,
ral', or its Examine	Ď	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes		Specify:		Jan, 5(6),	Specify:		
"natural",	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usua kind of wor	k done di	uring most (of working	,	16b. Kind of Bus	siness/In	dustry
han	ig E	Elementary/Secondary (0-12)	College (1-4or 5+)	Teleco	DO NOT us			onsu	Itant	Federal	Gov	ernment
nyge thert nt, th	e Co	17. Father's Name (First, Middle, Last)		rerece	AIIII					Maiden Sumame		CITHICITO
Mental Hyg arkad othe atic event,	To Be	Patsev Scarselli					T.,1	in Cr	rnape			
and mer is marks aumatic	F	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ng Address	(Street a				City or Town, S	State, Zip	Code)
		Anthony Scarselli	(Son)	936 I	orest	Bay	Cour	t, Ga	embrill	s, Mary	land	21054
fitam 2 rother		20a. Method of Disposition		Place of Disponentery, cre	osition (Nan	ne of ther place) T	an. B		20c. Location - 0	-	
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ri 14 ☐ Donation 5 ☐ Other (Specify)	Res	surrect	cion C	emet	ery	$\frac{200}{200}$	•	Clinton	, Ma	ryland
Important: Important: any injury once.		21. Signature of Fundamental Lee										rt, P.A. MD 20736
ysician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deal e cause on each line.	th. Do not en	ter the mod							Approximate Interval Between Onset and Death
ledical aminer		resulting in death)	Due to (or as a consec Conge.	uonan oil.		4 7	Eall	٥٨٨				Ha
	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	uence of):								1700077
sician and buriat-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Artemo:		the	Corre	do vo	nsen	lar Di	sease		years
	ical	L										
od by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3	⊒Ectopic pr ⊒ Other (sp					23d. Date Mon		ery Day Year
00	þ	Part II. Other significant conditions con Ventroular JA	6 4 h	- 4						6		he cause of death? pably 4 □Unkno
ate has been si page 2 should	Completed	Mixed Large +	Small Cel	1 Ly	mph	oma	-	_ '	24a. Was ar autops perform	y pr ged? de		psy findings availampletion of cause
certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death (Check only on	70		
n. After this ce funeral direc	n: To B	examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	28b. Time of		Bc. Injury Work	4 🗀 1401:			nce 6 Othe		y)
leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, st	M reet, factory		′es 2□N		f. Location (Sti City or Town		r or Rura	al Route Number,
within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 175 Certifying Phys	ician: To the best of my kno	owledge, deal	th occurred	at the tim	e, date and	place, an	d due to the ca	use(s) and mar	ner as s	tated.
the Fi	Medical	one)	er: On the basis of examina and manner stated.	ation and/or in				1 00001160			_	
To	2	29b. Signature and title of certifier	0 01-		290	. License	172	45		od. Date signed		-
		1 verall	P. Sterner	my.		1)	117	1-7	-	Jamua	My -	3,2004
5+1		30. Name and address of person who co Gerald P. Sterner.				-1				Marylan		720

			For State Registrar	State of I	Marylan		artment of H		and M		enez ()	04	0-412
			1. Decedent's Name (First, Middle, La	st)	 					2. Date of Death	1		3. Time of Death
	Physici /Medio		Tracy B. Schoon	naker					ŀ	January	2, 20	04	9:55 ^{p™}
Ĭ	Examin		4a. Facility Name (If not institution, give	e street and numb	er)		4b. City, Town, or	Location o	of Death		4c. County	of Death	
			Millennium Nursir	ng Center			Ellico					ward	
	Funeral Director		5. Social Security Number 221–12–3848	Gex 7. I⊠ M 2□F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day, 2/9/192	Year)	9. Birth Cou Nev	place (State or Foreign ntry) V York
	P .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	, Town or Lo	cation				_		10d. Inside City Limits
	eho	5	Md. Howar	ν 3	100.00,		cott City						1 ☐ Yes 2 ⊋No
	28a-1	ect	10e. Street and Number	<u> </u>			10f. Zip Code	<u>/</u>		10	g. Citizen of V	Vhat Cou	
	With Sa or	Funeral Director	8326 Sunset Driv	re				21043			-	JSA	,
	ms 2:	era	11. Marital Status	12. Was Decede		S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Orig	jin? (Spe	cify Yes or No-	14. Rac	e - Ameri	can Indian,
36	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Madical Examinar must be notified a	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	^{□ №} 194	^	f Yes, specify Cuba I□ Yes 2√2 No	n, Mexican Specity:	, Puerto F	tican, etc.)	Specify	k, White, ‴Wh	nite
21215-0036	2 hou	ted	15. Decedent's E	ducation	^{s:} 1943	16a. Deced	lent's Usual Occup	ation		1	6b. Kind of Bu		
215	Pin 7.	Completed	(Specify only highest gri	College (1-4	or 5+)	life. L	kind of work done o OO NOT use retired	auring most ()	of workin	g			
7	or the	Ö	12			In	surance I	Invest	igat	or	Ir	isura	ince
land	td be tilk lenta! Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last Benjamin Bevier		er:					(First, Middle, M izabeth		re)	
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at ance.		19a. Informant's Name/Relationship (Jane M. Schoonma	Type, Print)			g Address (Street a	and Numbe	r or Rura	Route Number,	City or Town,		
	ss 1 an of Heel item 2 other		20a. Method of Disposition		l c	lace of Dispo	sition (Name of natory or other place				Oc. Location -		
<u>Ĕ</u>	Pages nent of I ant: if ite ury or o		1 ☐ Burial 25 ☐ Cremation 3 ☐ 1 ☐ Other (Special Control of Cont		Met		ematory		./8/2		atonsvi	•	
Baltimore,	permit. Departimport. any inj		21. Signal re of Funeral Softion Lice	NOW THE PROPERTY OF THE PROPER	MOO845	5 4	. Name and Addres $112\mathrm{Old}\mathrm{C}$	s of Facility	Harr Dia P	y H.Witz ike Elli	ke's F	amil	y F.H.Inc. Md. 21043
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each	n line.	. Do not ente	er the mode of dying	g, such as	cardiac or	respiratory arre			Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or	as a consequ	uence of):	king Co	cas	-e	,,,,,			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequ	ience of):	- 10 (-				
8760,	icate be executed physiclan and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or	as a consequ	ience of):							
9	ertificat ding phy se as th	/Medi	IF FEMALE:	23c. If yes, outcor	me of pregna	nev							
O. Box	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth	2 ☐ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)	·			23d. Dat Mor		ory Day Year
s, P.O.	uires that the signed by detaction	y Ph	Part II. Other significant conditions	contributing to deat	h but not resu	ilting in the ur	idertying cause give	en in Part I.		23e. Did toba	icco use contr	ibute to t	he cause of death?
ğ	w require been sig should b									1 Tes	2 □ No	3 Prot	pably 4.20nknown
Division of Vital Record	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detach	Completed								24a. Was an autopsy perform	ed2~ d	eath?	psy findings available mpletion of cause of
ita	ian: artitica ctor, ,	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one)		
<u>></u>	Physician: this certitic ral director,	일	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa		ER/Outpatien		Nur Nur	sing Hom	e 5 ☐ Residen	ce 6 □Othe	r (Specif	(y)
ion o	Attending PI ir death, ector: After the	ation;	27. Manner of Death 1		njury Day Year)	28b. Time of Injury	28c. Injury Work M 1 🔲	at (? Yes 2 □ N		8d. Describe how	injury occurre	∍d	
Divis	of or Atte after dea Directo	Certification;	3 Suicide 6 Could not be determined	289. Place 01	Injury - At ho etc. (Specify	me, farm, stre	eet, factory, office	-3401	2	8f. Location (Stre City or Town,		er or Rura	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the be niner: On the basis and manner	s of examinat	wiedge, death ion and/or inv	occurred at the timestigation, in my op	e, date and pinion, death	d place, as h occurre	nd due to the cau d at the time, dat	ise(s) and ma e and place, a	nner as s	tated. the cause(s)
	To the P within 24 To the F complete	Me	29b. Signature and title of certifier	\cap			29c. License	number	11	290	d. Date signed	(Month,	Day, Year)
	1		30_Name and address of person who	completed cause of	of death (Item	23a) (Tiv o e. I	Print)	>000	/-!	2 "	RI	45	Day, Year) May lend
(0)	at		Ramesh Sabar	with 20	1-105	156	cre herre	No	ell	Load.	126/1	nnv	2/22/
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0. 6	2003 32. Regi	strar's Signat	tre	and .						

Physicia /Medic		1. Decedent's Name (First, Middle, Last								eg. No		
/Medic	an i								2. Date of Dea Month	Day	Year	3. Time of Death
	al	FRANCES ALICE	THOMPSON						January	2	2004	
Examin	er	4a. Facility Name (If not institution, give			_ ^		Location of	of Death			unty of Dea	
		Manor Care Nursi 5. Social Security Number 6. Se		last hirthday)	Lar If Under		If Under	24 Hrs.	8 Date of Birth			George's
uneral irector			M 280 F 83	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Dec.31,	1920	Was	thplace (State or Foreign punity) hington, D.(
show	_	10a. State 10b. County		ity, Town or Lo								10d. Inside City Limits 1X Yes 2 □ No
Sa-f.	ecto	Maryland Prince G	eorge's Co	11ege	Park 10f. Zip	Codo				On Citizon	of What Co	
Den	宣								'	_		ourid y ?
ns 23	erai	7105 Rhode Island	1 AVENUE 12. Was Decedent Ever in U	J.S. 13.		740 lent of Hi	spanic Ori	ain? (Sp	ecify Yes or No-	U.S.		erican Indian,
Priter library	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2t No					, Puèrto	ecify Yes or No- Rican, etc.)		Black, Whit	
yene. Tre Medical Examinat must be notified at	d by	3∑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:					nite
"nat edics	iete	15. Decedent's Edi (Specify only highest grad	le completed)	(Give	dent's Usua kind of wor DO NOT us	k done d	turina mosi	of work	ing	16b. Kind	of Business	Industry
other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years		sable		,			No	ne	
t t	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	e (First, Middle, I	Maiden Su	mame)	
9 0 9	To B	David Robert Thor	npson				Ethe	e1 E	. Kauffm	ıan		
7 is marke traumatic		19a. Informant's Name/Relationship (T	vpe, Print)	1	-				al Route Number			
item 27 other tr		Dolores A. Ulrich							e, Asbur			
5 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	removal nom State	Place of Dispo cemetery, crei								Town, State
ortant: injury o		* 4 □ Donation 5 □ Other (Specify,	For							Brenty	, boow	Maryland
Important: I any injury o once.		21. Signature of Funeral Service Licens	D +.	F	ORT L	INCO	s of Facilit LN FU	NERA	AL HOME			rv1and 20722
physician and ledical aminer sthe burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Dementia Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	thy quence of):								
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gned be de	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying ca	ause give	en in Part I,			acco use i		the cause of death?
been si should	etec								24a. Was a	1		
has ye 2	Completed								autops perform	V	prior to death?	itopsy findings available completion of cause of
certificate ha		Of Manager of arrad to modical						-/ 0 11		⊠ No	1 🗆 Yes	2 No
certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	EP/Outpation	* 2000	Othe			n <i>(Check only on</i> me 5 ☐ Reside		Othor /Con	ai6.)
After this funeral dir	H 1	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Bc. Injury Work	at		28d. Describe ho			sny)
neral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	lome, farm, str fy)	eet, factory	, office			28f. Location (Sti City or Town		umber or Ru	iral Route Number,
e Funeral Directed to by	edicai (sician: To the best of my kno ner: On the basis of examina and manner stated.									
To the Function	Me	29b. Signature and title of cortifier			29c.	. License	number		29	d. Date si	gned (Monti	h, Day, Year)
		1(-')		- M) – .	58182			Janua	ry 2,	2004
5)		30. Name and address of person who co			Print)							
)												

			For 1. State	State of Marylan	d / Dep	artment of H	lealth and N			gible.	01111
			Registrar		Ce	rtificate of	Dealli		Reg. No. 6	. U U 5	1) [4]
*	D.		Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Charles D.	Taylor				1 5	2004		6:54 A M
V	Examin	- 1	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. Cou	inty of Death	
			Washington Adven	tist Hospital		Takoma	Park		Mon	gomer	У
	Funeral		5. Social Security Number 6. Se		last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 8 29	h Vear)	9. Birth	place (State or Foreign
10	Director		236-62-2261	XM 2□F 67	Yrs.	Months Days	Hours Will.	8 29	193€	West	place (State or Foreign ntry) Virginia
			Usual Residence of Decedent								
	ylan		10a. State 10b. County	10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	Mar Feet	to	MD Prince G	eorge's Ri	verda:	le					1X Yes 2 □ No
	158 128a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?
	3a o	0	6808 Beacon Place			20737			U.S.A	1.	
	72 hours after death with the Maryland natural; or Items 23e or 28e-f show dical Exama not must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14.	Race - Ameri	
	Iten	ä	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No				o Rican, etc.)		Black, White,	etc. Lack
36	I, or		3 ⊠Widowed 4 □Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spi	ecify: DJ	Lack
21215-0036	Pon I	Completed by	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occur	pation		16b. Kind o	of Business/In	dustry
<u>ب</u> بې	n 72	Siet	(Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word)	king			
7	withi ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		unication			Gove	nment	
72	filed within Hygiene. Ithar than *	Ö	17. Father's Name (First, Middle, Last)				18. Mother's Nan		Maiden Sur	name)	
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$\frac{3}{5}$	should be and Mental is marked of aumatic eve	To	0 ,	Suna Deinel	10h Mail	ing Address (Street	and Number of Ru	en l Courto Alumbi	c City or To	um Stato Zi	Code)
ā	2 st		19a. Informant's Name/Relationship (7) John Taylor/S	•	6808	Beacon P1	ace Rive	dale, M	arylar	id 2073	37
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If of Health and Mental Hygiene. or other traumatic event, the Medical Exams not must be notified at					osition (Name of		Date		on - City or To	
0	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	١ ,	emetery, cre	matory or other pla				·	
Ē	Pa British ury		*4 □Donation 5 □Other (Specify			n Nationa		3-2004			
Baltimore,	permit. Departr Imports any inj		21. Signature of Funeral Service Licen	see		2. Name and Addre					L Home
m	88558		66	6	7	474 Lando	ver Road	Landove	r, Mai	yland	20785
	nysician /Medical Examiner		23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. SEPS Due to (or as a conseq	uence of):	iter the mode of dyn	ng, such as cardiac	or respiratory ai	rest,		Approximate Interval Between Onset and Death
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	e be executed scien and burial-transit	Examiner	that initiated events	· END ST	AGE	REN	AL D	1SEA	56-		
oʻ	exe en ar rial-t	Ä	resulting in death) Last	Due to (or as a conseq	uence of):	0.	PAIL				
760,	te be ysici	cal		d. KESPIK	ATO	RY	FAIL	-URC	<u> </u>		
9	g phy as th	ed									
). Box	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d	Date of deliv Month	ery Day Year
P.0	that the de ed by the detached	Phy	Part II. Other significant conditions of			and a bit an annual an	una in Dort I	23a Did t	obacco uso	contribute to t	he cause of death?
Ś	w requires that been signed be should be deta	b	Part II. Other significant conditions of	onthouting to death but not res	unung in in o 1	underlying cause gr	ven ar ranti.	1	res 2□N		babiy 4 Munknown
of Vital Records,	equi	Completed			- · · · -			, ,	195 2 1	0 3 1 10	Dably 4 Monkhown
Š	aw r	ple						24a. Was		4b. Were auto	opsy findings available empletion of cause of
ď	The I	E						perfo	rmed?	death? 1 ☐ Yes	2 X No
ta		a	25. Was case referred to medical				26. Place of Dea				-
5	Physiclan: this certific ral director,	00	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA Ot	000	lome 5 🗆 Resi		Other (Speci	ful
of	Phys r this rai di	5.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju	ry at	28d. Describe			•97
Division	Attending I r death. ector: After by the funer	Certification:	1 ☑Natural 5 ☐ Pending		Injury	Wo	rk?]Yes 2∐No				
Si	uttendii death. ctor: A ctor: A y the fu	ca	3 Suicide 6 Could not b	0 200 Diago of Injury At h	ome farm s	4		28f Location (Street and N	umber or Rur	al Route Number,
<u>></u>	fter Sirect in by	ŧ	4 Homicide determined	building, etc. (Specific	(y)	ileet, lactory, onlos		City or To			
	To the Hospital or Attendir vithin 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medicaf Exar	nysician: To the best of my kno niner: On the basis of examina	owledge, dea	ith occurred at the ti	me, date and place	, and due to the	cause(s) and	d manner as s	stated.
	the lin 2. the F	ed	one)	and manner stated.							
	200	Σ	29b. Signature and title of certifier	112 -51	/		se number			gned (Month.	
			Chandras	ller Harry.	MI	MD	5285	5	0/-	05 -	2004
) [10/		30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре						
-1			Chandrasek Korapa	ti M.D. 7207-F	Hand	over Park	wav Green	nbelt. M	arvlar	d 2077	70
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature			,			
	Regist		JAN 0 7 2004		has	1. 1.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:00 P M January 2004 Steve A. Tomajko /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Lorien Nursing & Rehabilitation Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer)
Months Days Hours Min. Sept 7, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months **™** M 2□ F 88 1915 Pennsylvania 133 07 4738 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Howard Clarksville the 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number ŏ United States 5930 Great Star Drive Unit 204 21029 Itama 23a Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1943-45 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐XNo Specify: þ 35 Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Owner Restaurant f Health and Mental Hygi Item 27 is marked other 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Stephen A. Tomajko Anna Chernicky 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21029 5930 Great Star Drive Unit 204 Clarksville, MD Date Date 20c. Location - City or Town, State Stephen A. Tomajko Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 'Department of H Important: If Ite any injury or of 1 Burial 2 Tremation 3 Removal from State Metro Crematory Jan 7, 2004 Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 hours **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner 3 weeks Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): sician Box 68760 Physician/Medical phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Huntingtons Disease, Dementia, PVD, ASCVD 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 (No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █No 2 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral D 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie JANUARY MA 000 60560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACK RIVER NECK RD. BALTIMORE, MA KHETERPAL 201-109 32. Registre's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

with the Maryland

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Walters JANUARY 11,2004 9:34 а William

4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 334 VIRGINIA AVENUE APT # 4 CUMBERLAND ALLEGANY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign
COVID) 5. Social Security Number **Funeral** Months 213-24-7392 Usual Resident **X**□M 2□F 74 Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Iteme 23a or 28a-f show the Mudical Examiner trust be notified at X 1□Yes 2□No Cumberland Allegany Be Completed by Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 334 Virginia Avenue Apt 4 Pages 1 and 2 should be filed within 72 hours after deeth vent of Health and Mental Hygiene.

Ant: If item 27 is marked other then "Tatural", or Iteme 23 and it if item 27 is marked other then "Tatural", or Iteme 13 any or other traumatic event, jirs Amolical Examinar mans. 12. Was Decedent Ever in U.S.
Armed Forces?
UMYes 2 MNo
WYes Give
Year or Dates: 1948-50 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No 3 ☐ Widowed X☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B&O Railroad laborer 12 18. Mother's Name (First, Middle, Malden Sumame) Emma Mae Broadwater Walters 17. Father's Name (First, Middle, Last) William A. Walters 9b. Majling Address (Street and Number of Rural Roma Number Trandwn, State, ZMP)e)21502 19a. Informant's Name/Relationship (Type, Print) daughter Donna Porter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MD 1/14/2004 Rocky Gap Veterans Cemetery Flintstone 1 Daurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. NamScarbellis Furneral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 ramino 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) atheroscientic cardiovascular disease **Physician** Hypertensive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of): Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 📆 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Rother (Specify) at scene 1 □XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier **OCME** JANUARY 12,2004 Aw.

State Registrar

the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year) 2 1 2004

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32. Registrar's Signature MARIE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mid

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year ROBERT LEROY WEBBER JANUARY 9 ,2004 57 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death HUNDER YEAR' HUNDER 24 Hrs. 8. Date of Birth (Month, Day, Year)

SEPT • 22, 1937 CIVISTA MEDICAL CENTER
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) CHARLES

9. Birthplace (State or Foreign Country) **Funeral** Director 66 192-30-3270 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner quat be notified at 1 ☐ Yes 2 No Directo MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5529 LITTLEBROOK DRIVE Items 23a 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

**Milyes 2 | No if Yes, Give 1 9 6 0 -- 6 6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. t Never Married 257 Married ŏ 21215-003 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than NAVAL SURFACE WEAPOI Elementary/Secondary (0-12) College (1-4or 5+) 12 SENIOR INTELLIGENCE OFF. U.S.GOVT. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IRVIN WEBBER MARTHA KEEFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Importent: If item 27 Is
any injury or other treu MARIE WEBBER-SPOUSE 5529 LITTLEBROOK DR. LA PLATA, MD. 20646 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 1-12-04 ALEXANDRIA, VA. 21. Signature of Fureral Service Licensee. MO0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician awann O Olii /Medical Dya to (or as a consequence of): Examiner 0 arcinoma Sequentially list conditions, if any, leading to immediate cause. Enter University of Cause (Disease or injury that initiated events Examiner Due to (or as a cons uence of): attending physician and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) the ☐Yes 2☐No 9 Unknown 9 Unknown ۵ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Probably 4 Unknown Deed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page autopsy performed certificate 1□ Yes 2 No rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes ٩ 1 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospitel or Attending After 5 Pending investigation To the Hosping.
within 24 hours after death.
To the Funerel Director: Air 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRZA ALIKHANI, MD 118 LA GRANGE AVE. LAPLATA, MD 20646 Day, Year), Day, Year 31. Date filed (Month, Day, Year) State

Registrar

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Division of Vital Records,

			1- For Amend Item 26 per CS/DVR, G827, 01/21/04d	artment of Health and N	lental Hygie	ne No2004 01418
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physici		WILLIAM JAMES WOOD JR.		January	14 2004 8:25p M
	/Medio Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth
			Rebecca House Group Home	Potomac		Montgomery
	Funeral		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday,		8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)
	Director		0/9-10-9255 82		Mar 20,19	21 New York
	put		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation		10d. Inside City Limits
	sho	č				1 ☐ Yes 2 X ☐ No
	78a-f	ect	Virginia Fairfax McLe	d.N 10f. Zip Code	100	Citizen of What Country?
	ours after death with the Marylan ral', or items 23a or 28a-f show Examinar must be notitied at	Funeral Director	1178 Huntover Court	22102	109.	· ·
	ss 23	era			ecify Yes or No-	U.S. of A.
	iterr iterr	5	Armed Forces? 1 ☐ Never Married 2(X) Married 1 ☐ Yes 2 ☐ Yo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
336	urs af	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🛱 No Specify:		Specify: White
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-1 show idical Examinat De notified at	Completed by	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
215	within 7 ene. than "n	ple		kind of work done during most of work DO NOT use retired)	arg	
2		5	4 EI	ectrical Engineer		Manufacturing
힏		Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Sumame)
<u>la</u>		2	William James Wood	Alice M	arion Dun	ham
Maryland	s 1 and 2 should Heelth and Mer item 27 is marke other traumatic			ng Address (Street and Number or Run		,
	and n 27			Huntover Court, M		
ore	0 O		20a. Method of Disposition 1 Disposition 1 Disposition 20b. Place of Disposition 20c. Place of Disposition commetery, creations and commetery, creations are commetery.	matory or other place)		. Location - City or Town, Stete
Baltimore,	permit. Pages Department of I importent: If it any injury or o		'4 □Donation 5 □ Other (Specify) Union	Cemetery Jan :	l9 2004 L	eesburg, Virginia
alt	ppart poort ny inj		21. Signature of Funeral Service Licensee			eral Chapel, Inc.
	207		Willing (Medourghan	P.O. Box 1316, Le		A 20177-1316 Approximate
	Physician /Medical Examiner	ler	23a. Per1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	heelmonaey Obstrutu	Clee.	Interval Between Onset and Death
68760,	The law requires that the death certificate be executed site been signed by the attending physicien and bage 2 should be detached for use as the buriat-transit	edicai Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last c Due to (or as a consequence of):			,
.O. Box	at the death certific by the attending pl tached for use as t	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that in signed b	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
l Records,		Completed			24a. Was an autopsy performed	
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?		(Check only one)	A 1//
of	Physician: this certifical ral director.	ဥ	1 Yes 2X No Hospital: Wampatient 2 ER/Outpatien			6 Dother (Specify) HSM (US)
n	Dr je e	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yeer) Injury	Work?	28d. Describe how in	njury occurred
Sio	endi eath. or: A	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	el or Attending s after death. ni Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or within 24 hours after To the Funeral Direction Completely filled in E	Medical	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the top	Σ	29b. Signature and tale of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
				56147		115/04
	10		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)		101
	10		Nafreen Kango, M.D., 7610 Carroll A	venue, Takoma Parl	, MD 2091	2
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de de		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mar		artmen rtificat			d Me		ene 3. No. 2004	01419
	Physici	20	Decedent's Name (First, Middle, La	•					2	. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Barbara	Garber		Zimme				January		11:30AM
	Examin	er	4a. Facility Name (If not institution, given Frederick Memo		al			Location of Di erick	eath		4c. County of Dea	
	Funeral Director			Gex 7. Age (1□M 2□F	In yrs. last birthday 69 Yrs.) If Under Months		If Under 24 H	Hrs. 8	Date of Birth (Month, Day,) Oct. 20	^{9. Bi} , 1934 Mai	rthplace (State or Foreign ountry) Cyland
	Maryland -f show	tor	10a. State 10b. County Maryland Frederi		Oc. City, Town or L Jeffers				·			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28s	Funerai Director	10e. Street and Number 4521 Timbery	Drive		10f. Zip	2175	55		100	g. Citizen of What C	ountry?
036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show collest Extending the motified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes	er in U.S. 13.	Was Dece If Yes, spe 1 Yes		spanic Origin? n, Mexican, Pu Specify:	? (Specification)	y Yes or No- can, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
1215-0	d within 72 ho giene. In than "natur In e M. o cel	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	edent's Usu e kind of wo DO NOT u	ork done d se retired	turing most of	working		Retail/Cr	
Maryland 21215-0036	be filed ital Hygi od other avant, I	o Be	17. Father's Name (First, Middle, Las. William Mcle		DE-	rr em	DIOYE	18. Mother's I		First, Middle, Ma	aiden Sumame)	dits
	nd 2 lith a 27 is r trat	-	19a. Informant's Name/Relationship David Theodore Zi	3,	sband 452	l Tim	bery				City or Town, State, MD 2175!	
Baltimore,	Part Ind		20a. Method of Disposition	fy)		matory or o	eran C	emetery .		9, 2004	Jefferson	n, MD
Ball	permit. Departr Importu any inji		21. Signature of Funeral Service Lice	The MC	10255	106	East	<u>Chure</u>	h St	., Fred	neral Home derick, M	e 0 21701
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Carcing Due to (or as a of		the mod			diac or ri	espiratory arres	st,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed at the been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):							
.O. Box 6	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pi □ Other (sp					23d. Date of de Month	olivery Day Year
rds, P	w requires that been signed is should be det	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying o	ause give	en in Part I.		23e. Did toba		o the cause of death?
Il Records,		Compieted							_	24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vital	lcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	/					Death (0	Check only one)		
of \	Physician; this certific ral director,	P	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie			4 🗆 (40) (5)(1)	g Home	5 Resident	ce 6 □Other (Spe	ecify)
	Attending P r death. ector; After t by the funera	ation:	27. Manner∕I Death 1 □Natural 5 □ Pending 2 □ Accident investigation		/ear) 28b. Time Injury	of A	28c. Injury Work	rat (? Yes 2 □ No	280	d. Describe how	injury occurred	
Division	itel or Attures after de rel Directo	Certification:	3 Suicide 6 Could not l	building, etc.						City or Town,		
	o the Hospitel or within 24 hours after To the Funerel Director Completely filled in D	edicai	29a. Certifier ↑ Certifying P (Check only one) 1 Medical Exa	hysicien: To the best of miner: On the basis of e and manner state	xamination and/or is	th occurred nvestigation	at the time i, in my or	e, date and pl pinion, death o	ace, and	d due to the cau at the time, date	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	com com	Σ	29b. Signature and title of certifier	hum Itu	L HD	290	c. License	number 24767	79	290	Date signed (Mon	th, Day, Year)
	W-/		30. Name and address of person who	completed cause of dea							1-11-1	
	Sta	ite	31. Date filed (Month, Day, Year)	Grillo G	s Signature	ہاری ہے	せし	03 tue,	deri	ic, Mr	21703	·
	Regist		JAN 21	2004	es de la	assile						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Joseph Christopher Benner 1710 2004 4b. City, Town, or Location of Deeth /Medical 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Stella MAris at Mercy Medical Center Baltimore City WA If Under 24 Hrs. 6. Sex If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Days 1√ M 2□ F Hours Months 480-54-8780 56 Director January 27, 1947 TA Usual Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2 ₩ No Severn Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1719 Wood Carriage Way 21144 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 1 Yes 2 □ No If Yes, Give 69–97 Yeer or Dates: 1 ☐ Never Married XX Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify white ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) US Military 12 Intelligence Officer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maynard B. Benner Leota Christopher 19a. Informant's Name/Relationship (Type, Print)
Song Benner / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 Wood Carriage Way, Severn Maryland 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant View Cemetery January 22, 2004 Hartley, IA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature Funeral Succession Victor P. Doda, Jr. 22. Name and Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chase on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ST N unu Examiner Due to (or es e consequence of): Examine ng physician end as the buriel-transit The law raquiras that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): resulting in death) Last attanding | signed by the a id be datached f Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part 1. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown <u>ک</u> 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy has 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After thi funerel 27. Manner of Death 28c. Injury et Work? Certification: 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 1- Naturel 5 Pending 1 ☐ Yes 2 □ No death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dic completaly filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier J40854 Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print) 301 31. Date filed (Month, Day, Year) Riseberg ST PAUL PL 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

			State of Maryland / Depa 1- State Registrar AMEND ITEM 27&28b PER ME G827 1/22@##.	artment of Health and Mental I	Hygiene 01421
	Discortat		Decedent's Name (First, Middle, Last)	2. Date of Month	
	Physici /Medic		Robert L. bausinger, Sr.	o l	1 19 04 0615 M
	Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
			University of Norsland/Shock Trans	na Baltimore (ity N/A
	Funeral		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month)	, Day, Yeer) Country)
-	Director		203-20-0658	FEB.	28, 1929 Pennsylvania
	land wo		10a. State 10b. County 10c. City, Town or Loc	cation	10d. Inside City Limits
	Mary 	ţō	Maryland Harford	Abingdon	1 ☐ Yes Ž☐ No
	7 28a	rec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	72 hours after death with the Maryland Interest, or frame 23a or 28a-f ehow dical Examiner mast be notified at	by Funeral Director	1214 Abinchar Drive	21004	USA
	deat	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Apped Forces?	Vas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9	after or its	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No WWTT 1	Yes 2 No Specify:	
8	urel',		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	and appears.	Specify: White
7	nation of the	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
12	within ene. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)	no NOT use relired) It Supervisor	34
d 2	Hygid Hygid Sther	Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	Maintenance Mechanic
an	Mental Mental arked o	To Be	Lewis L. Bausinger	Nelly Unk.	ions, maiosin comanney
Maryland 21215-0036	and Men Is marke	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address (Street and Number or Rural Route Nu	umber. City or Town. State. Zin Code)
	od 2 lith a 27 Is				on, MD 21004
re,	es 1 a of Hea fitem rothe		20a. Method of Disposition 20b. Place of Dispos		20c. Location - City or Town, State
E	Pages nent of int: If its iry or o		4 Donation 5 Other (Specify) Metro Cres	matory, Inc. 1/20/04	Baltimore, MD
Baltimore,	permit. Pages 1 al Department of Hea Important: If item eny injury or othe		21. Signature of Furieral Service Licensee Man 1	Name and Address of Facility	-11 T
m	88 5 8		Dawn F. McDonald 25	Name and Address of Facility emation Society of Mary 9 Frederick Road Balt	imore. MD 21228
â			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or respirator	ry arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Arch thmic	Onset and Death
7	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Arrhythmia	3
20	LAdillilei	_	Sequentially list conditions.	g tuilure Due To	Multiple Injuries
	Pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	74 <u></u>	, , , , , , , , , , , , , , , , , , ,
	ate be executed hysician and the burial-transit	хап	tat initiated events resulting in death) Last C. Due to (or as a consequence of):	ad Lajvey	1//
8760,	ate be ex hysician he buria	dicalE		Ectopic pregnancy Other (specify) CERTIFICATION APPROVEDED IN	TON EXAMINER
687	fficate g phys	edic	0.	Misser	Diche
Вох	death certifica attending ph of for use as t	<u>S</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ATTON APPROVE	23d. Date of delivery
œ.	death e atte	Physician/Med	in the past 12 months? 1 Ves 2 PMn 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify) CERTIFICATION	Month Day Year
0	that the de led by the a detached i	hys	9 ☐ Unknown 9☐ Unknown		
ŝ	Se us	by F	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I. 23e. D	id tobacco use contribute to the cause of death?
ord Ord	w requir been si should	ted	typertension	1	☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
ecc	has be	pie	Myocardial Infarction	24a. W	As an 24b. Were autopsy findings available prior to completion of cause of
<u> </u>		Completed	Cerebrorosiulo- Accident		erformed? death?
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical example?	26. Place of Death Check on	1
Division of Vital Records,	Phys this al di	- T	Hospital: 1 Inpatient 2 □ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		
u	ding I	tion	1 □ Natural 5 □ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☑ No C 4	be how injury occurred
18	or Attendate death Director:	fica	3 ☐ Suicide 6 ☐ Could not be	SVULI	O (Street and Number of Rural Route Number.
2	after after Dire	Certification:	4 Homicide building, etc. (Specify)	City or	Town, State)
1/	pspita hours mera y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, and due to the	he cause(s) and manner as stated.
,	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	(Check only 2 Medical Examiner: On the basis of examination and/or inve	istigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
	with com	Σ	29b. Signature and title of certifies	29c. License number	29d. Date signed (Month, Dey, Year)
	10		C3 MD	15389	1/19/04
	M		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	reene ST Baltimore	MP 2/202
30.	Registra		31. Date filed (Month, Day, Year) JAN 2 2 2004 32. Registrar's Signature		

Physic /Medi		1. Decedent's Name (First,	Middle, Last)					2. Date of Death	h Day	Yeer 3.	Time of Death
		THOMAS	DANIEL	BAU	ER			January			06 A
Exami		4a. Fecility Name (If not ins			7)	4b. City, Town, or Loca			4c. County	of Deeth	
		317 Spanian 5. Social Security Number	ds Necl		- days last birth	Centre		0.00		Anne's	
uneral irector		217-84-2423 Usual Residence of Decede	1 🔀	M 2□F	ge (In yrs. last birthd 41	Months Days Ho	urs Min	8. Date of Birth (Month, Dey, IOV . 1 , 19	62 Year)	9. Birthplece (Country) MARYLAI	
r 28a-f show	tor	MD QU	County IEEN AN	NE	10c. City, Town o	r Location EVILLE					side City Limit □Yes 2 X N
23a or 28 at be not	al Director	10e. Street and Number 317 SPANIAR	DS NEC	K ROAD		10f. Zip Code 21617	,	10	og. Citizen of \	What Country?	
ural, or Itams 23a or al Examinar must be	d by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Div	Married	12. Was Deceden: Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?]No	 Was Decedent of Hispan If Yes, specify Cuban, Me Yes 2 No Specify No Specify Cuban 	ic Origin? (Spec exican, Puerto R ecify:	cify Yes or No- lican, etc.)		e - American Inc ck, White, etc.	lian,
the Medical	Completed	(Specify only Elementary/Secondary (C	cedent's Educ highest grade 0-12)	College (1-4or	5+) (G	ecedent's Usual Occupation live kind of work done during e. DO NOT use retired)		g		usiness/Industry	
	Cor	8		-0-	D	RYWALL CONTRA			BUILDI		
9 0	To Be	17. Father's Name (First, M RICHARD GEO	RGE BA				BETTY J	(First, Middle, M UNE WIL	LIAMS		
7 -		19a. Informant's Name/Rel PATRICIA BAU			317	ailing Address (Street and N SPANIARDS NE					
Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 XBurial 2 Crema 4 Donation 5 Ott		emoval from State	cemetery, o	sposition (Name of crematory or other place) I MEMORIAL PAI	Da R IK 1-1 6		Oc. Location -	City or Town, Si	ete
Imports any inju		21. Signature of Funeral Se	ervice Licepse	el fer fur		22. Name and Address of F FELLOWS, HELFF 408 S. LIBERT	NBEIN &				
			-	Due to (or as	s a consequence of):	tion				-	t and Death
sician and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse or injury that initiated events resulting in death) Last	b.	Due to (or as	10000	itIOII					
utending physician and or use as the burial-transit	cai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1	d.	Due to (or as Due to (or as do. If yes, outcome	s a consequence of): s a consequence of): s a consequence of): e of pregnancy 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date Mor	e of delivery	Year
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	d.	Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	s a consequence of): s a consequence of): s a consequence of): e of pregnancy 2 Fetal death it time of deeth	3 □Ectopic pregnancy	Part I.		Mor	th Day	Year
as been signed by the attending physician and 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months; 1 Yes 2 No 9 Unknown Part II. Other significant co	d. 23	Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	s a consequence of): s a consequence of): s a consequence of): e of pregnancy 2 Fetal death it time of deeth	3 □Ectopic pregnancy 5 □ Other (specify)	Part I.	1 Yes 24a. Was an autopsy performe	Moracco use contr	th Day	Year se of death? 4 Munknown dings available n of cause of
as been signed by the attending physician and 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1 Yes 2 No 9 Unknown Part II. Other significant co	d. 23	Due to (or as Due to (or as Bc. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	s a consequence of): s a consequence of): s a consequence of): e of pregnancy 2	3 DEctopic pregnancy 5 Other (specify) a underlying cause given in F	Place of Death (24a. Was an autopsy performs 1 Yes 2	Moracco use contraction and the second secon	ibute to the caus 3 Probably Vere autopsy finition to completio eath? Yes 2 No.	Year 4 Munknown dings available n of cause of
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant co 25. Was case referred to meanminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 P	d. 23 Inditions cont	Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	s a consequence of): s a consequence of): s a consequence of): s a consequence of): s of pregnancy 2 Fetal death to time of deeth out not resulting in the	3 Ectopic pregnancy 5 Other (specify) a underlying cause given in F 26. F ient 3 DOA Other: 4 of 28c. Injury at 24 vis. 4	Place of Death (24a. Was an autopsy performe 1 Yes 2 Check only one 5 Residen d. Describe how	Mor acco use contr 2 \(\text{No} \) 24b. V ad? \(\text{No} \) No \(\text{1} \) ce \(6 \) Cothe	ibute to the caus 3 Probably Vere autopsy finition to completion eath? EXYES 2 No.	Year 4 Munknown dings available n of cause of
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	d. 23	Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	s a consequence of): s a conse	26. Filent 3 DOA Other: 41 Work?	Place of Death (in Nursing Home 28) You No Un 28	24a. Was an autopsy performed by School 12 Yes 20 Check only one) of 5 Residen d. Describe how alknown	More than the state of the stat	ibute to the caus 3 Probably Vere autopsy finition to completion eath? EYes 2 No. or (Specify) at add Spaniar OS	Year se of death? 4 Munknown dings available n of cause of
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant co 25. Was case referred to meaxaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pictor 29. Accident 3 Suicide 6 Code 4 Homicide Certain 29a. Certifier 1 Certain 1 Certain Certain 29a. Certifier 1 Certain 29b. Was decedent 1 Certain 29a. Certifier 1 Certain 29b. Was decedent 1 Certain 29a. Certifier 1 Certain 29a. Certifi	anditions continued in the deciral including elements in the determined in the deter	Due to (or as Due to	s a consequence of): s a consequence of):	26. Filent 3 DOA Other: 41 Work?	Place of Death (24a. Was an autopsy performed the second of	More tand Number State) More and Number State) More and Number State) More and Number State)	bute to the caus Probably	Year 4 Munknown dings available n of cause of SCENE
this certificate "as been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant co 25. Was case referred to meanmine? 1 Yes 2 No 27. Manner of Death 1 Natural 5 P 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Mercedent M	edical Homeonic Could not be etermined dical Examined	Due to (or as Due to	s a consequence of): s a consequence of):	3 Ectopic pregnancy 5 Other (specify) a underlying cause given in F 26. F ient 3 DOA Other: 4 ient 4 Work? 1 Yes street, factory, office	Nursing Home 28 X No Un 28 Ce e and place, and death occurred	24a. Was an autopsy performed the second of	Acco use control acco use control acco use control acco use control acco acco use control acco acco acco acco acco acco acco ac	bute to the caus Probably	Year se of death? 4 XUnknown dings available n of cause of SCENE SCENE
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant co 25. Was case referred to meaxminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 P 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifier Medical Content one) 1 Certifier Medi	edical Homeonic Could not be etermined dical Examined	Due to (or as Due to	s a consequence of): s a consequence of):	26. Fuent 3 DOA Other: 4 Work? a Underlying cause given in Fuent 3 DOA Other: 4 Work? a Underlying cause given in Fuent 3 DOA Other: 4 Work? a Underlying cause given in Fuent 3 DOA Other: 4 Work? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork? at Mork?	Place of Death (1) Nursing Home 28 X No Un 28 Ce e and place, and death occurred Der	24a. Was an autopsy performed the second of	More accourse control 24b. V 2	bute to the caus Probably	Year 4 Munknown dings available n of cause of c SCENE NECK Ro

			1 - For State Registrar		aryland / Depa <i>Cei</i>	artment of F			ene 2004	01423
	Physici /Medic		1. Decedent's Name (First, Middle, Las Catherine	Byus				2. Date of Death Month January	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give North Arundel H	ospital		G1	r Location of Death en Burni	e	4c. County of Deat Anne	m Arundel
	Funeral Director		5. Social Security Number 6. S 217-18-1246 1 Usual Residence of Decedent	ex 7. Age	e (In yrs. last birthday) 8() Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 29	9. Birth Co	thplace (State or Foreign buntry)
	Maryland B-f show	tor	10a. State 10b. County Maryland Anne Anne Anne Anne Anne Anne Anne An	rundel	10c. City, Town or Lo		Burnie			10d. Inside City Limits 1 ☐ Yes 2X☐ No
	is after death with the Marylan ', or Items 23a or 28e-f show cominer must be notified at	ral Directo	10e. Street and Number 6662 Roberts Cour	rt Apt. 85		10f. Zip Code	21061	10g.	. Citizen of What Co	•
336	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	No I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0036	within 72 hours ene. than "natural", ne Modical Exa	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Decec (Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired		ring 161	b. Kind of Business/l	Industry
Maryland 21	be filed tal Hygi d other	Be	9 17. Father's Name (First, Middle, Last) Edward Cunt	ningham		Homemak 		e (First, Middle, Mai		nold
	and 2 should leath and Mening 27 is marke	ር	19a. Informant's Name/Relationship (1		The same of	ng Address (Street a	and Number or Run		ity or Town, State, 2	lip Code)
Baltimore,	Pages 1 ent of H nt: If iter ry or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Dispo cemetery, cren Meadowride	sition (Name of natory or other plac	a) Jan.	Date 21 200	c. Location - City or 1 kridge Ma	
Balt	permit. Departm Importar any injure once.		21. Signature of Fuperal Service Lider	4.			tain Road	Stalling d. Pasader	gs Funeral na. MD 211	Home, P.A.
	Physician /Medical		23a. Part1. Enter the disease, or composition of the composition of th	a Sept	icemia	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	b. Kena	a consequence of):	Ve_				
, 20,	ificate be executed g physician and as the burial-transit	Il Examiner	cause. Enter Underlying Causes (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):	ent Fo	antinice			
ox eg/en		/Medical	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome	of pregnancy				23d. Date of deliv	ven/
	that the death cert ed by the attendin detached for use	hysician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1⊡Live birth 4⊡Pregnant at 9⊡ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
coras, r	w requires that the de been signed by the s should be detached	ted by P	Part II. Other significant conditions or	ontributing to death bu	ut not resulting in the un	nderlying cause give	en in Part I.		co use contribute to 2 ☐ No 3 ☐ Pro	
e L	: The law icate has be page 2 sh	Completed						24a. Was an autopsy performed 1 Tyes 2	prior to co	topsy findings available ompletion of cause of 2 No
OI VIE	y Physician: or this certific oral director,	n: To Be	27. Manyer of Death	Hospital: 1 Inpatier		t 3 DOA Othe	er: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how in	e 6 Other (Speci	ify)
DIVISION	r Attending er death. ractor; After by the funel	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ıry - At home, farm, stre	_ M 1□Y	res 2 □No	28f. Location (Street City or Town, St	t and Number or Rur	ral Route Number,
2	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical Cer	29a. Certifier 1 Certifying Phy	ysician: To the best of iner: On the basis of	of my knowledge, death	occurred at the tim	e, date and place, a	and due to the cause	e(s) and manner as	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner state	THE M.D.	29c. License			Date signed (Month,	
	0		30 Name and address of person who co	ompleted cause of de		Waspital	Drive	, Glen &	surnie, t	1D, 21061
	Sta Registr		31. Date filed (Month, Day, Year)	2 2 200 gistra	r's Signature	Sporte	4			

Byus, Catherine

			For State Registrar	State of	f Marylan	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of H	ealth a Death	and M	ental Hyg	iene 2 (004	0 1	+24
			1. Decedent's Name (First, Middle, Las	t)							2. Date of Deat Month	Dav	Yeer	3. Time of [
	Physici /Medio		Ruby	I	ee			Cath			anuary	15 2	004	03:57	7 м
1	Examir		4a. Fecility Name (If not institution, give	street and nun	nber)			_	Location o	f Death		4c. Count	y of Death		
			Sinai Hospital 5. Social Security Number 6. S		7. Age (In yrs.	last hirthdayl	Bal 1		If Under:	24 Hrs.	8. Date of Birth		9. Birthr	plece (State or	Foreign
н	Funeral Director			[©] M XCXF	79	Yrs.		Days	Hours	Min.	(Month, Day, 01 16	Year) 24	Cou	iC	
	P .		Usual Residence of Decedent		100 0	ty, Town or Lo	antion							10d. Inside City	Limits
	ahow	7	10a. State 10b. County			ltimo								1 ⊠ Yes	
	the M	Director	MD NA 10e, Street and Number		Ба	11611110	10f. Zip	Code			1	Og. Citizen of	What Cou	ntry?	
	3a or		4669 Falls Road	٩				2120	1 0			11 5	. A .		
	death	Funeral	11. Marital Status		dent Ever in U	l.S. 13.				gin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ce - America		
9	a within 72 hours after death with the Maryland Jiene r than "natural", or items 23a or 28a-f show the M. circal Examiner must be notified an	y Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 Mo e No		1□Yes 2		Specify:		, , , , , , ,	Speci	he		
Ö	hours tural',	ed by	3 XWidowed 4 □ Divorced 15. Decedent's Ed	Year or Da	ates:	16a Dece	dent's Usua	I Occupa	ation			16b. Kind of E		ack	
215-0036	9 2	plet	(Specify only highest gra	de completed) College (1	-4 or 5+)	(Give	kind of wor DO NOT us	k done d	luring most	of workir	ng			,	
212	filed within Hygiene. ther than "	Completed	12th grade	na	-401 3+)	Fa	ctor	A M					ctor	. Х	
nd		Be	17. Father's Name (First, Middle, Last)					İ			(First, Middle, N		me)		
Maryland	d 2 should be th and Mental 7 is marked of traumatic eve	우	Grady Long 19a. Informant's Name/Relationship (Tuna Brinth		10h Mailir	a Addross	(Street 1			Graves Route Number,		State Zir	Code)	
Mai	12 s h ar 7 is trau		Mable Jackson-				•				Balti	•		21215	
	s 1 and 2 if Health item 27 i		20a. Method of Disposition		20b. F	Place of Disponentery, crea						20c. Location			
E O	00 = =		1 ☑ Burial 2 ☐ Cremation 3 ☐ 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify							1/2	20/04	Randa	llst	own,	Md
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Uper	see		22 M	Name and	Addres	s of Facilit	y St	Balti			21215	
yle.	1 ×		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that cone cause on e	aused the deat ach line.	th. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Betw Onset and D	neen
	Physician		Immediate Cause (Final disease or condition	a. C	recor	my 1	A6pu	1	Die	eas	(Onsei and D	eatti
1	/Medical Examiner		resulting in death)		or as a consec				4		Stevens	P. 21-	Para	Α	
ľ	2001	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	or as a conseq	J r no	2 3	yno	MM	l.	210000	1018	Tour	NI/KE	-
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		Diab	etes									
oʻ	ate be executed hysician and the burial-transit		resulting in death) Last		or as a conseq		0	1			 				
3760	ate be hysici the bu	Ical	•	d	Torral	we	ary	6hn	rese	Д					
x 68	death certificate be executed attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, out	come of pregna	ancv						22d D	ato of dolar		
Вох	attend for us	clan	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth 2 ☐ Feta ant at time of c	al death 3	Ectopic pre					1	ate of delive onth	-	ear
P.0.	that the de	hysi	1 Yes 2 No 9 Unknown	9□ Unkno	own			.,							
	6 7 6	by P	Part II. Other significant conditions of	-		4	nderlying ca	use give	n in Part I.					he cause of de	/
ord	w require been sig		Degeneral	we	20m	<u> </u>	DISE	ens			1 🗆 Ye	s 2 🗆 No	3 🗌 Prot	oably 4 🔲 🗸	nknown
Vital Records,	e law r has be je 2 sh	Completed									24a. Was ar autops perform	/	Were auto prior to co death?	ppsy findings a impletion of ca	vailable use of
E B		Com										No	1 Yes	2 No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Δ Othe	A.P.		(Check only one				-
of	Phys or this oral di	To :	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o		Bc. Injury Work	4 🗀 (40		ne 5 Reside 28d. Describe ho			y)	
ion	stending F death. ctor: After y the funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		h, Day Year)	Injury	М		r? Yes 2 □ I	No					
Division	al or Attends after death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place	of Injury - At h ng, etc. (Specia	ome, farm, str fy)	eet, factory	, office		2	28f. Location (St. City or Town		ber or Rura	al Route Numb	19 <i>1</i> ,
·V	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	niner: On the ba											
	To the within To the Comp	Ž	29b. Signature and title of certifier	2	<i>-</i>	1219	29c.	_	number		29	d. Date sign			
7	1		▶ Etre	sav -		V())		2	96619				7100		
	U		30. Name and address of person who					7. 1			Sonte	215	Ra	U no.	1 2/2
	Sta	to.	31. Date filed (Month, Day, Year)		egistrar's Sana	& 21		enti		71	omu	200	1,00	. , , , ,	1 616
5	Sta Regist		JAN	A & LUL	4 Sien	Eur x	4 4	bank	2)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:58PM Cuffee **Physician** JANGARY 2004 /Medical Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BACTIMOLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 2 3 1 7 2 7. Age (In yrs. last birthday). 9. Birthplace (State or Foreign County) 5. Social Security Number 6. Sex **Funeral** 1 □ M 200 F 213-18-0619 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at BATIMORE MD 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? BEAVER BROOK 21212 U.S.A. death y Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: or Iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Ozban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. I: If item 27 Ie marked other then "natural", or Ite r or other traumatic event, It a Modical Examina 1 ☐ Never Married 2 ☐ Married BLACK Maryland 21215-0036 1 ☐ Yes 2 1 No Be Completed by 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BROWN SR. VIRGINIA 19b. Malling Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12015 MISTY KOSE COURT CLARKS VILLE, MD 21029 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Pages 1 S CEMETERY 1.24.04 ARBUTUS, MARYLAND
22. Name and Address of Facility VAUGHT C. GREENE FINER HOME 1 MBurial 2 ☐ Cremation 3 □Removal from State permit. Page Department of Importent: If any injury or once. ARBUTUS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROAD BACTIMINE MARYLAND 21212 Varsh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thmia Physician Arrhy disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Coronon Disease Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examiner Due to (or as a consec To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Be Completed by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown Hypetension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 autopsy perform funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient examiner? 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title discrifie Intend 40059388 Weisman Modich 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

David Weismon, 5601

Raver Blod.

Loch 2004 Register's Signatur

s Signature

, Baltimore MO

	an	1. Decedent's Name (First, Middle, Last)	DAVIS	>	2. Date of Dea Month JANVA	Day Year	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give street and r		o. City, Town, or Location of		4c. County of Deel	
Funeral Director		5. Social Security Number 6. Sex 11 M 2 X F	1	Under 1 Year II Under 2 onths Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day	Year) Co	thplace (State or Foreign ountry)
M II		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits
Sa-f sh	Director	MD NA	Baltimore				XXYes 2 No
la or 21		10e_Street and Number 3400 Barkley Woods Road 34 00 Barclay Woods F		21244		Og. Citizen of What Co	•
ral", or Itams 23a or 28a-f show Examinar must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes.	ecedent Ever in U.S. 13. Was Forces? II Yes	Decedent of Hispanic Origins, specify Cuban, Mexican, Yes XXNO Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
Avdical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0·12) College	d) (Give kind	's Usual Occupation d of work done during most NOT use retired)	of working	16b. Kind of Business	/Industry
ther the	Con	4th grade na 17. Father's Name (First, Middle, Last)	Hou	se Wife	s Name (First, Middle,	Home Maiden Sumame)	
arked othe atic event,	To Be	Christopher Davis			Davis	,	
Department of health and Important: If item 27 le m eny injury or other traum once.		19a. Informant's Name/Relationship (Type, Print) Edna Azore-Daughter 20a. Method of Disposition XXBurial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify) 21. Signmure of Funeral Service Licensee	20b. Place of Disposition cemetery, cremato Gardens o 22. Na Mar	of Faith 1 ame and Address of Facility Ch F/H Wes	Date /24/04	Baltimore 20c. Location - City or White Mar	Town, Stete
ysician ledical		resulting in death)	at caused the death. Do not enter the neach line. PSIS to (or as a consequence of):		ardiac or respiratory ari		Approximate Interval Between Onset and Death
physicien and the burial-transit to the buri	dicai Examiner	Sequentiary list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):	HEMORE	lAG €		LONG STANON ~ G
by the attending phy tached for use as the	Physician/Med	in the past 12 months?	egnant at time of death 5 Oth	opic pregnancy her (specify)		23d. Date of del Month	livery Day Year
a S	0	Part II. Other significant conditions contributing to	•	rlying cause given in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	
peng pe de	þ	DIABETES ISCHEMI	C CARDIOMYOP	ATHY.	1⊔Υ		robably 4 Unknown
e has been signed age 2 should be de	Completed by	MYCCARDIAL NEAR TEMPORAL ARTOR	ections, ADR	TIC STENOS	24a. Was a autop perfor	24b. Were at prior to death?	utopsy findings available completion of cause of
n. After this certificate has been signed funeral director, page 2 should be de	To Be Completed by	MYCCARDIM NPA TEMPORAL ACTOR 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	RCTION, AORT	TIC STENOS ALTEMY BYPA 26. Place	24a. Was a autopperform 1 Yes of Death (Check only or sing Home 5 Resid	an 24b. Were at prior to death? 2∠No 1 □ Yes	utopsy findings available completion of cause of
ath. rr: After this certificate has been signed te funeral director, page 2 should be de	To Be Completed by	MYCCAZDIM NPA TEMPGRAL ACTOR 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 27. Manner ol Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be 28e. Pla	RCTION, AORT	TIC STENOS ACTIVM BYPA 26. Place (3 DOA Other: 4 Nurs Work? M 1 Yes 2 N	24a. Was a autoperfor 1 Yes of Death (Check only or sing Home 5 Resid 28d. Describe h	24b. Were at prior to death? 22No 1 Yes	utopsy findings available completion of cause of 2 No
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n. After this certificate has been signed funeral director, page 2 should be de	To Be Completed by	MYCCAZDIM APA TEMPORAL ACTOR 25. Was case referred to medical examiner? 1	AOCTION, AOC	TIC STENOS ANCTEND BYPA 26. Place of the state of the s	24a. Was a autopperfor 1 Yes of Death (Check only or sing Home 5 Resid 28d. Describe home) 28f. Location (S City or Town)	24b. Were at prior to death? 22kNo 1 Yes ance 6 Other (Spe) aw injury occurred (reet and Number or Rin, State) ause(s) and manner as at a and place, and due	utopsy findings available completion of cause of security) ural Route Number, s stated.

			1- Stote Amend Item 8	State of Maryland / Deper fh G845 7-15-	partment of Health and ertificate of Death	Mental Hygiene	2004 01427
	Physici /Medio		1. Decedent's Name (First, Middle, Last	400		2. Date of Death Month Da JANUARY 1	y Year 5, 2004 9:43P. M
)	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	ath 4c	. County of Death
			207 NORTH LINWOOD 2 5. Social Security Number 6. Se		BALTIMORE av) If Under 1 Year If Under 24 Hr	S. P. Date of Righ	0.000
b	Funeral Director	à		M 2 PF Yrs	Months Days Hours Mil		9. Birthplace (State or Foreign Mary Java)
	yland		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	e Mar	ctor	MD	Balti	nore		1 € es 2 □ No
	th with th	Funeral Director	10e. Street and Number 207 N. Linwo	D Avenue	21224	10g. Cit	tizen of What Country?
9003	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Evantine must be neithed at	ğ	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? of Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	d within 72 t giene. ir then "natu Ine Medice	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Segondary (0-12)	e completed) (G	cedent's Usual Occupation ive kind of work done during most of we. DO NOT use retired)	orking 16b. K	Private
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ine Ma	To Be C	17. Father's Name (First, Middle, Last) Emmit Ho	1+	18. Mother's Na	ame (First, Middle, Maiden	Sumame)
	1 and 2 shi Health and em 27 is m ither traum	,	19a, Informant's Name/Relationship (Ty John Dunn	Husbard) 20	ailing Andress (Street and Number or F	Rural Route Number, City of BUK/	or Town, State, Zip Code) MD 4/22 4
Baltimore,	8 = 2		20a. Method of Disposition Burial 2 Cremation 3 F		sposition (Name of rematory or other place)	Date 20c. Lo	ocation - City or Town, State
Iţi.	mit. Pag bartment bortant: I injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Teen	count emetery.	1/23/04/30	Hinory, MD
Ba	permit. Departrimportal		E W	" Lux	Valight Cree	Lestemera	l Services 21212
-	- 5		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death. Do not	enter the mode of dung, such as cardia	ac or respiratory arrest,	Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition		and blunt force i	n wie c	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	unce orarii jorce i	igaries	
larg.	LAGITITICI	10	Sequentially list conditions, if any, reading to immediate	Due to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
0,	an an		resulting in death) Last	Due to (or as a consequence of):			
68760,	ificate be executed g physician and as the burial-transit	edlcal),			
O. Box 6	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
٦	res that the de signed by the a be detached to		Part If. Dther significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	ise contribute to the causa of daath?
of Vital Records,	w requires been sign should be	ed by				1 ☐ Yes 2.X	ÑNo 3 Probably 4 Unknown
ဝ၁	law re as bee 2 sho	Completed	<u></u>			24a. Was an autopsy	24b. Were autopsy findings available
<u> </u>		Com				performed? 1∑Yes 2☐ No	prior to completion of cause of death? 1 ☑Yes 2 ☐ No
Vita	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	ospitaf:	0+	eath (Check only one)	
ō	Phys or this seal di): To	1 X Yes 2 No 2. No 27. Manner of Death	28a. Date of Injury 28b. Time	of 28c, Injury at	Home 5 Residence (28d. Describe how injur	SXIOther (SpecifyAT SCENE
ion	nding ath. r: Afte	atlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	For (Month, Day Year) Junyary 15, 2004 For Significant State of	28c. Injury at Work? 1 Yes 2 MNo		s assauted
Division	Hospital or Attending Pi 24 hours after death. Funeral Director: After ti tely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☑ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number,
	ppital or At ours after c leral Direct filled in by		•	home		207 N. Linwa	sod the BULLIMOVERD
	e Hospital 24 hours a Funeral letely filled	edical	29a. Certifier 1 ☐ Certifying Physical Check only 2 ☑ Medicel Examination	sicien: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. License number	29d. Dat	e signed (Month, Day, Year)
,	1		Josharth	ee Der MD	O.C.M.E.	JANUA	ARY 16,2004
	N		30. Name and address of person who co	- '11	e, Print)		
			TASHA Z. GREENBERO 31. Date filed (Month, Day Year) 2 2		111 Penn Street,	Baltimore, M	Maryland 21201
	Sta Registr		JAN 2 2	2004 ^{32. Registrar's Signature}	Low		

		•	1 - For State Registrar	State of W	iaryiana		artment of F			Reg. No.	2004	01428
∯ æ	. 7		Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of Death
	hysicia /Medica		Raymond	L. Du	vall	Jr.			January	16	2004	5:48 PM
	xamine		4a. Facility Name (If not institution, giv	e street and number	r)		4b. City, Town, or	Location of Death		4c. Co	ounty of Death	
ALC:	Page.	Ш	104 Kingbrook Ro					nthicum			ine Arur	
1900	neral		5. Social Security Number 6. S 213-14-0268	Sex 7. A I⊠M 2□F	ige (In yrs. las	.,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	, Year)	9. Birthp Coun	lace (State or Foreign try)
	ector		Usual Residence of Decedent	Α –	82	113.			Nov. 14	1 192	1	MD
yland	Mo to		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
Man		to	Maryland Anne Ar	unde1			Lin	thicum				1 ☐ Yes 2 ☒ No
th the	D1 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Coun	itry?
ath w	238		104 Kingbrook Ro	ad			210	90			USA	
ar de	E E	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
d 21215-0036 Itled within 72 hours after death with the Maryland Hygiene.	o.	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∑Yes 2 ☐ If Yes, Give Year or Dates] No		1 ☐ Yes 2 ☑ No	Specity:		S	pecity: Wh	ite
5-0036	E E	edt	15. Decedent's E			16a. Deced	ient's Usual Occup	ation		16b. Kind	of Business/Inc	dustry
21.5 27.0°	U U	Completed	(Specify only highest gra Elementary/Secondary (0-12)			(Give	kind of work done o DO NOT use retired	during most of wor	king	700. 74.74		240119
212 d with giene	artie and a	E	10	College (1-40)	3+)		Fireman			US G	lovernme	en t
be fife	Vent,	Bec	17. Father's Name (First, Middle, Last,		0			18. Mother's Nam			ımame)	
Vald b		To I	Raymond L.	Duvall	Sr.			Helen	Cook			
Maryland d 2 should be fife th and Mental Hy	Item 27 is marke other traumatic		19a. Informant's Name/Relationship (ng Address (Street					Code)
	her ti		Frances Miller	(daught		-	Kingbrook sition (Name of	100 100 100	Liberton .			
	E =		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐		con	netery, cren	natory or other plac	Outro			tion - City or To	
Baltim permit. Pag Department	njury		* 4 □ Donation 5 □ Other (Specification 21. Signature of Fineral Service 1) × 1	W	Met		ematory I Name and Addres					Maryland
Ba perm Depa	any injury o		21. Signature of Parleta Selvice 32	1/-								Home, P.A.
			23a. Part 1. Enter the disease, or com	lications that cause	ed the death.		111 Mount				וט בוובב	Approximate
Dhua	iolon		Immediate Cause (Final	cause on each	line.			•				Interval Between
Phys						+	!	14.011	Dave a	a 8	10.7	Onset and Death
/Me	dical		disease or condition resulting in death)	a.recuy Dup to (or a	s a conseque	t co	rebro	vasau	lar a	cci	dent	Vears
	_		resulting in death)	a. COU	s a conseque	t co	rebro	vasuu XIm	lar a	(cci	dent	years
Exar	dical niner	iner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Finer Underlying	0.	s a consequent		rebro rilla	tion	lar a	(cci	dent	Years Years
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	Physici /Medi		HARRY DALNEKOFF		2. Date of Death	18 ^{ay} 2004	3. Time of Death 4:15 A M	
4	Examir			4b. City, Town, or Location of E ARNOLD	Dealh	4c. County of Deat		
ti-	Funeral Director		5. Social Security Number 116-14-1456 Usual Residence of Decedent 7. Age	(In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, OCT.12,	1913 9. Birt	hplace (State or Foreign suntry) SCOTLAND
	e Maryland Sa-f show diffed at	Director	10a. Stale 10b. County MD BALTIMORE	10c. City, Town or Lo	BALTIMORE			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th		1500 BEDFORD AVENUE #406		10f. Zip Code 2120		og. Citizen of What Co	untry?
036	be filed within 72 hours after death with the Maryland la! Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Exacting must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Married 12. Was Decedent E Armed Forces? 1 Married 15. Was Decedent E Armed Forces? 1 Married 15. Was Decedent E Armed Forces? 1 Married Forces?	· WWII '	Nas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, P I ☐ Yes 2 🌠 No Specify:		14. Race - Ame Black, White Specify:	ncan Indian,
21212-0036	filed within 72 ho Hygiene. ther than "natur int, the Mcdical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1.4or 5-	(Give	lent's Usual Occupation kind of work done during most of OO NOT use retired)	working	16b. Kind of Business/	,
Maryland		To Be Co	17. Father's Name (First, Middle, Last) SAMUEL	DALNEK		Name (First, Middle, M	faiden Sumame)	LABINSKY
	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) BARRY J. DALNEKOFF / SON	2532	g Address (Street and Number of CARROLLTON ROA			
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gal	permit Depart Import any in		21. Signature of Fineral Servicer Licenses	Cs 89	000 REISTERSTOWN		SVILLE,MD.	
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1/	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or inv	occurred at the time, date and placestigation, in my opinion, death o	ace, and due to the cau ccurred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
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	M.		30. Name and address of pers o completed cause of dea		rint)			200
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Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dev **Physician** 4:10PM Finking 2004 20 GLORIA ANN EDER /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Burnie Arunde Has Anne Arundel If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Funeral Days Hours Min. Months 1 ☐ M 2 🔀 F 212-36-0802 81 Director JUNE 6, MARYLAND Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Depertment of Heelth and Mentel hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a Stete 10h County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director ANNE ARUNDEL GLEN BURNIE MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 186 MARGATE DRIVE 21060 Be Completed by Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ho If Yes, Give Year or Dates: Specify Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) LOLA REYNOLDS CLARK RUFUS IRVIN SHORT 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8008 SILVER FOX DRIVE GLEN BURNIE, MARYLAND 21061 GARY EDER - SON 20b. Place of Disposition (Neme of cemetery, cremetory or other place JAMBARY 20c. Location - City or Town, State 20e. Method of Disposition Puriel 2 Cremetion 3 Removel from State GLEN HAVEN MEM. PARK 24, 2004 GLEN BURNIE, MARYLAND 4 🗆 🕅 onetion 5 Other (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility 21061 KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 23a. Part 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** PREUMONIA Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as e consequence of) Due to (or es a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Division of Vital Records, P.O. Box 68760.

Be Completed by within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Certification: To

25. Was case reference examiner?	
27. Majoner of Datt	1
Naturel	5 Pendin
2 Accident	inve <i>s</i> tig

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Pending investigation 6 Could not be determined

Hospital: Inpatient

32. Resistrar's Signature

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 □ No 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in the cause of examination and/or investigation in according to the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and or examina Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner steted.

29b.	Signature	and title of certifie				
			7			

filed (Month, Dey, Year)

29c. License numbe mo

29d. Date signed (Month, Dey, Yeer) 20

1 ☐ Yes 2 ☐ No

s of person who completed cause of deeth (Item 23e) (Type, Print) 301

26. Place of Death (Check only one)

State Registrar

Medical

DHMH 16 Rev 6/95

the Hospital

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Maryland / Department of Health and M		g. No 2 0 0 4	01432		
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth Month	Day Year	3. Time of Death		
	/Med			January	19, 2004	5:20pm		
	Exami	ner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Lo		4c. County of Deet			
			2111 St. Heather Lane Gambril		Anne Ar			
	Funeral Director		5. Social Security Number 216-68-1467 Usuel Residence of Decedent 6. Sex 1	8. Date of Birth (Month, Day, Aug. 7,	Year) 9. Birt 1914 Was	hplace (State or Foreign untry) hington, DC		
	land land	Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	72 hours efter deeth with the Maryland nature!', or frems 23a or 28a-f show asel Examiner must be nottled at		Maryland Anne Arundel Gambrills					
			10e. Street and Number 10f. Zip Code	10	g. Citizen of Whet Co	untry?		
		aiD	2111 St. Heather Lane 21054		United Sta	ites		
	er dee	ine	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
21215-0036	ours efter al', or its Examina	b Be Completed by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 💥 No Specify: Year or Dates:		Specify:	White		
5-0	n 72 hours *natural',		15. Decedent's Education (Specify only highest grede completed) [Key kind of work done during most of worki life. DO NOT use retired)	ing 1	6b. Kind of Business/	Industry		
121	within ene.		Elementery/Secondary (0-12) College (1-4or 5+)					
	e filed value of the t		11th Homemaker 17. Fether's Neme (First, Middle, Last) Homemaker	(First Middle M	Own Home	2		
Maryland	Mentel Merked o		Edward W. Kines Mary	Ciss	,			
Σ	2 should be end Mente is marked sumatic evanua	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rure			(in Code)		
Z	nd 2 lifth el 27 in r trac				, Maryland	•		
ē,	of Hei		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or			
Ē	Peges nent of int: if Ik		I Li Buriai 2 Est Cremation 3 Li Hemoval from State	21/2004	Odenton.	Maryland		
Baltimore,	permit. Peges 1 and 2 should be filed within Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, it is Mense.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A.					
m	88 E 88	0	ematory, . n, Maryland	r.A. 1 21113				
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock or heart failure. List only one cause on each line.	r respiratory arres	st,	Approximate Interval Between		
	Physician Medical Examiner				†	Onset and Death		
1			Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):					
	uted d ansit	edicai Examiner	b. 0-30-00-00-00-00-00-00-00-00-00-00-00-00					
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Box	ith ce tendi	lan/	d		1			
	the a	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tob	acco use contribute	to the cause of death?		
, P.O	The law requires that the death certificete be executed ate hes been signed by the attending physician and page 2 should be detached for use as the buriel-transit	by Phy	altypoiners absense	Yes	Yes 2 No 3 Probably 4 Unknown			
rds	w requires that been signed t should be det	8	<i>'</i>	24a. Wes an		Vere autopsy findings		
Records,	s bee	Completed		performe	C	vailable prior to ompletion of cause f death?		
æ	The law rte hes bage 2	ШO		↑L Yes	2) Z No 1	☐ Yes 2☐ No		
Vital		Be	25. Was case referred to medical examiner?	(Check only one)				
4	S 50	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Tesiden	ce 6 □Other (Spec	ify)		
ם	ring Ph	Ë	↑ Natural 5 Pending (Month, Dey Year) Injury Work?	28d. Describe how	injury occurred			
Sio	tor: A	cati	2 Accident investigation M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number,				
Division	or Al after of Direction by	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,		rai Houle Number,		
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	n 24 h	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	d at the time, date	e and place, and due	to the cause(s)		
	Vithii To the Comp	ž	29b. Signature and title of certifier 29c. License number		I. Date signed (Month			
	Α.		> 15ery m/ D002957	/ (1/20/2	2004		
-			30. Name end address of person who impleted cause of death (Item 23e) (Type, Print) ALVD, 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature AN 2 2 2004	CROF	TON M	004		
	Sta	ite	31. Date filed (Month, Day, Yeer) 32. Megistrer's Signature					
	Registr	ar	JAN 2 2 2004 A Com De April 1					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

AA	. GALL		For State Registrar	State of Ma	•	epartment of F Certificate of			g. No.	01433
ı	Physici /Medic		1. Decedent's Name (First, Middle, La. Rita Ann Gall					2. Date of Death Month January	Day Year	3. Time of Death 14:46 P
	Examin		4a. Facility Name (If not institution, give		lson 16		or Location of Death		4c. County of Death	
	Funeral Director		3/3-/0-224/	ex 7. Ag	e (In yrs. last birti	rs. Flkric Hday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Sept.	Howard 9. Birthp Cour 24, 1961	olece (State or Foreign otry) MI
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MI Fator	ı	10c. City, Town	or Location Delta Townshi	i p		1	0d. Inside City Limits 1 ☐ Yes ※XX No
	th with the 23e or 28e	Funeral Director	10e. Street and Number 812 N. Creyta Road	i		10f. Zip Code	8917	10	g. Citizen of What Coul USA	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, it is Medical Exercition must be incitified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed XX Divorced	12. Was Decedent Armed Forces? 1 Yes 201 If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2		cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
21215-0036	in 72 ho	Completed	15. Decedent's E- (Specify only highest gra	ide completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of workind)	ng 1	6b. Kind of Business/In	dustry
	filed within Hygiene. other than "	Com	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Truck Drive		(E) A 6:	Transporta	tion
land	buld be filed Mental Hygi arked other atic event, I	To Be	17. Father's Name (First, Middle, Last, Allen B. Knachel	1			18. Mother's Name	nie M. Com		
Maryland	1 and 2 should I Health and Meni 16m 27 Is marke other traumatic		19a. Informant's Name/Relationship (Laurie Hoppe / Sist			Mailing Address (Street N. Crayts Roa			City or Town, State, Zip	Code)
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	y)	BAyvie	Disposition (Name of y, crematory or other pla w Crematory			Oc. Location - City or To Baltimore M	
Balt	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service Licer	Victor P.	Doda, Jr.	Charles L. S		cal Home,	Inc. 1501 Eas Baltimore MD	t Fort Avenue
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. HEAD Due to (or as	ne.	ERMAL INJI		r respiratory arre	St. VHALATION	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of					
. Box	iaw requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	cy		23d. Date of delive Month	ery Day Year
rds, P.O	w requires that the been signed by should be detact	þ	Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to t s 2 No 3 □ Prof	he cause of death? pably 4 Unknown
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Vital	ilcian: certific rector.	o Be	25. Was case referred to medical examiner? 1 ※Xes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 TER/Ou	tpatient 3 DOA	26. Place of Death	1.70	nce 6 🔀 Other (Specia	W At agono
Division of	Attending or death. ector: After by the fune	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined	28a. Date of Inju (Month, Da in 136 28e. Place of In building, e	iry Year) 28b. 1 Year) 2 jury - At home, fa	ime of 28c. Injury Wo	iry at ork? ≸Yes 2 □No	DRIVER IN MUL	w injury occurred OF SEMI-TO TI-VEHILIE meet and Number or Run State) NULTHB	COLLISION
>	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		nysician: To the best	of my knowledge of examination an	death oppured of the t	tme, data and place.		usa(s) and manner as a ite and place, and due t	
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	1. At	fa		M.E.		od. Date signed (Month, January 14,	
	10	1	30. Name and address, person who		death (Item 23a)		nn Street,	Baltimo	ore, Maryla	nd 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	book				
DI	IMU 17 Day 1/3	2001	JAN 6 6 EUC	The same of the sa			·			

JAMES E GORDON 04-00438 DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland	/ Department	of Health	and Mental	Hygiene 🤈
	Cartificate			6-

Physician /Medical Examiner
Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than *natural*, or iteme 23e or 28e-f ahow any injury or other traumatic avent, if a Medical Expriner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State of Maryland State of Maryland	•	tificate of Death	urid ivie		eg. No.	104	O was
ž	1. Decedent's Name (First, Middle, Last)			2	2. Date of Deal Month	h Day	Yeer	3. Time of Death
in al	James Elmer Gordon			J	ANUARY		04	1:30 a M
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	f Death		4c. Count	ty of Deeth	
	57 SUMMIT AVENUE		HAGERSTOWN				INGTON	
	5. Social Security Number 6. Sex 187-42-8157 6. Sex 1 M 2 F 51	birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. M	Date of Birth (Month, Day) IAY 2,	Year) 1952	Coun	olace (State or Foreign htry) sylvania
	Usual Residence of Decedent 10a State 10b County 10c City, T	·	- diag					0d. Inside City Limits
ŏ	Maryland Washington 10c. City, T	OWII OI LO	Hagerstow:	'n				1 ☐ Yes 2 XNo
ect	10e. Street and Number		10f. Zip Code	11	1	0g. Citizen of	What Cour	ntry?
	57 Summit Avenue		21740				USA	
era	11 Marital Status 12. Was Decedent Ever in U.S.	13. \	Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican,	gin? (Speci	ify Yes or No-		ce - Americ	
Be Completed by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:		r Yes, specny Cuban, Mexican, 1 □ Yes 2 🂢 No Specify:	, Puerto Hi	can, etc.)	Speci	ack, White, ify: Wh	nite
ted	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	tent's Usual Occupation kind of work done during most	of working	,	16b. Kind of I	Business/In	dustry
mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most DO NOT use retired) Idscaper			Co	lf Co	urco
S	17. Father's Name (First, Middle, Last)	Бап		r's Name (First, Middle, I			ourse
o Be	James Elroy Gordon		Bet	tv M	arie V	Jagnei	r	
٦		19b. Mailir	ng Address (Street and Number					Code)
	Betsy Rose/Sister	P.O.	Box 96 Wine	dber	, PA	15963	3	
	20a. Miditiod of Disposition	e of Dispo	sition (Name of natory or other place)	Da		20c. Location	- City or To	own, State
		o Cre	ematory, Inc.					, MD
	21. Signature of Juneral Service Line 1999 Edward A. Gregorchik	22 2	Name and Address of Facility remation Soc 99 Frederic	ciet k Ro	y of Mad Ba	MD, Ir Ltimor	nc. ce. M	D 21228
	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between
	Immediate Cause (Final disease or condition	na						Onset and Death
	resulting in death) Due to (or as a consequent	nce of						
_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequent	nce of):						
nine	cause. Enter Underlying Cause (Disease or injury							
Exal	that initiated events c. The control of the contro	nce of):						
edical Examiner	d							
fed						-1		
an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de		Ectopic pregnancy				ate of deliver	ery Day Year
Be Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	h 5 ☐	Other (specify)				TOTAL T	Suy Tou.
Phy	Part II. Other significent conditions contributing to death but not resulti	ng in the u	nderlying cause given in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of death?
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фшо					autops perform		death?	mpletion of cause of
O a	25. Was case referred to medical		26. Place	of Death ((Check only or			
To B	examiner? 1X Yes 2 □ No Hospital: 1 □ Inpatient 2 □ EF	VOutpatier	04				ther (Specif	AT SCENE
n: T	(Month Pay Vons)	Bb. Time of		28	d. Describe h	ow injury occu	urred	
atlo	2 Accident investigation January 16, 2004		A M 1 ☐ Yes 2 ☑ N	No 5	ubject	han	ged	selt.
rtific	3 ★ Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	reet, factory, office		City or Town	n, State)		al Route Number,
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Medical Certification:	29a. Certifier 1 Certifying Physicien: To the best of my knowle (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	edge, deat n and/or in	n occurred at the time, date and vestigation, in my opinion, deat	id place, ar th occurred	nd due to the c d at the time, d	ause(s) and n late and place	nanner as s i, and due to	tated. the cause(s)
Mec	29b. Signature and title of certifier		29c. License number			9d. Date sign		
	Joseph Show her M	n	OCME		J	IANUARY	7 160	, 2004
	30. Name and address of person to completed cause of due in (Item 2							
	Tasha Z Greenberg M.D.	111	Penn Street, E	Balti	more, M	arylan	d 212	01
ite	31. Date filed (Month, Day, Year) 32. Registrar's signatur	Θ	! Soul					
ar	OMIE N N FOOD PROPERTY	Sur Sund	- AND STATE					

State

Registrar

them is forth

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, 2. Date of Death 3. Time of Death Month **Physician** GIEE VANDORRIA 0832 Jan 4 2004 /Medical 4a Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATTI MUM

If Under 24 Hrs. 8. Date of Birth

Hours Min. Townth, Dev. Year)

11 NE 30, 1963 If Under 1 Year 7. Age (in yrs. last birthday) Birthplace (Stata or Foraign
 Country) **Funeral** Days 215 · 90 · 762 Usual Residence of Deceder Months 1 □ M 2 🖫 F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Was Decedent Ever in U,S. Armed Forces? 11. Marita Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Haalth and Mental Hygiene. 1 Never Married ☐ Yes 2 Yes, Give 2 No 2 Married Baltimore, Maryland 21215-0020 Specify: KI ACK 1☐ Yes 2☑No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highest greda complated) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) (h1)t and Mental Hygie is marked other 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be NATHANIE 19b. Mailing Address (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Coda)
401 N. BENDED INE. BALTIMORE, MD 21224 19a. Informant's Name/Relationship (Typa, Print) Department of Haalth a important: If Item 27 is any injury or other trac MUTHER 20b. Place of Disposition (Nama of cematery, cramatory or othar placa, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1.20.04 BACTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Spacify) VAUGHTY C. GREENE FUNERAL 21. Signature of Funeral Service Licensee 4905 YORK ROAD BALTIMORE, MO 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Completed by Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): $GC \subset VQQQV$ Division of Vital Records, P.O. Box 68760, Syramose Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has been s irector, pege 2 should 1 Yes 244 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 12 Inpatient edical Certification: To | 1 Yes 2/X No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State) fillad in by 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filted To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 0 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lower arredo Street 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar 1. Decedent's Name (First, Middle, L.	State of Marylai		rtificate o		2. Date of	Reg. No Death	6 2 6	3. Time of Death
Physici		~ 11	Lee		Geah	r Vr.	Month Janua	ry 2		12:58 A
/Medic		4a. Fecility Name (If not institution, gi		1		, or Location of D			County of Deat	h
			yview Medical Ce Sex 7. Age (In yrs		Balti.		Hrs. 8 Date of	Rinth I	V/A	holaga (State or Fore
uneral irector			1 1 M 2 □ F 3	-	Months Day		Hrs. 8. Date of (Month,	Dey, Year)	965 M	hplace (Stete or Fore untry) D.
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el', or items 23a or 28a-f show Examinar musi be notified at	ō	MD. Baltim		Dunda.						1 □ Yes 2 🔀
r 28a-	Director	10e. Street and Number			10f. Zip Code)		10g. Cit	izen of What Co	ountry?
23a o	alD	8114 Bullneck Ro	ad		212	22			USA	
tems ar m	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent o	f Hispanic Origin ıban, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No-	 Race - Ame Black, Whit 	
l, or	by Fi	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2X N	o Specify:			Specify: W	hite
	ted	15. Decedent's 6	ducation	16a. Dece	dent's Usual Occ	upation	fadriaa	16b. K	ind of Business/	Industry
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	2	19a, Informant's Name/Relationship		19b. Maili	ng Address (Stre		or Rural Route Nu	mber, City o	or Town, State, 2	Zip Code)
reasili aliu iem 27 le m sthar traum		Ellen C. Weller	mother	8114	Bullnec	k Road,	Dundalk,	MD. 2	1222	
5 = 2		20a. Method of Disposition	20b.	Place of Dispe	osition (Name of matory or other p		nuary	-	ocation - City or	Town, State
ant: If		1 XBurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		k Lawn	Cemeter		4, 2004	Dune	dalk,Md.	
Important: If any injury o		21. Signature of Funeral Service Lice	nsee	00 6	2. Name and Add onnelly	ress of Facility Funeral	Home Of	Dunda	alk, P.A	A.
12.50		23a. Part I. Enter the disease, or coi shock, or heart failure. But only	nolications that caused the dea	th Dobot en	110 Sol]	ers Poi	nt Road,	_Dunda	alk,Md.	21222 Approximate
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ed by the attending physic detached for use as the b	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pregnar ⊒ Other (specify)	ncy			23d. Date of del Month	ivery Day Year
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certificate rector, pag	Be	25. Was case referred to medical examiner?	-				Death (Check on	ly one)		
this or al dire	은	1 ☐ Yes 2 No		ER/Outpatie	nt 3 DOA		ng Home 5 ☐ R			cify)
After funer	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time o	W	juryat /ork? ∐Yes 2∐No	28d. Descri	oe now inju	y occurred	
of in by the fu	Certification:	3 Suicide 6 Could not determine		home, farm, st	reet, factory, offic	ee .		n (Street ar Town, State		ıral Route Number,
To the Funeral Discompletely filled in	Medical (29a. Certifier (Check only one) Certifying F	hysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, dear nation and/or in	th occurred at the ovestigation, in m	time, date and p y opinion, death	place, and due to to occurred at the tin	he cause(s ne, date and	and manner as I place, and due	stated. to the cause(s)
within 2 To the complet	M	29b. Signature and title of certifier				nse number		29d. Da	te signed (Monti	h, Day, Year)
<u></u>		- Acar	-		Re	eltlmore)	Jane	vary 2	1,2004
' [5. 11 A F.	o completed cause of death (Ite	n 23a) (Type.	Print)	11	ml	2122	.1	
	1	Pr. John M ECKMA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SOPM **Physician** The DREEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Street Baltimore archine If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign
 Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2ØF 220-50-MARYLand Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "natural", or Itama 23s or 28s-1 show traumatic event, the Madical Examinat must be notified at Baltimore 1 PYes 2 No Md Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number With 2121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Pages t and 2 should be filed within 72 hours after 1 ☐ Yes 2 [[2] If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 (12 No Specify: BLack 1 ☐ Yes 2 TNo Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry omestic Elementary/Secondary (0-12) College (1-4or 5+) TOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Larri GREEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21313 19a. Informant's Name/Re tionship (Type, Print) 5,5teR Caroletta 741 N. Caroline St. Department of Health ar Importent: If Item 27 Is ony injury or other traugnes. Balto. Ma Sones 20b. Place of Disposition (Name of cemetery, crematory or other p. 20a. Methed of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodhawn Cem, ` 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Approximate Interval Between 23a. Part 1. Enter the disease shock, or heart failure 1 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final / disease or condition resulting in death) Onset and Death Burkitts Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exar iner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performs 1 Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther: 1 ☐ Yes |2 No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide filled the Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person n/timore 40

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Mog

32. Registrar's Signature

	4	For State Registrar	State of Maryland		ite of Death	Reg. F	Com had to 19	01438
		1. Decedent's Name (First, Middle, La	nst)			2. Date of Death Month	Year Year	3. Time of Death
hysician /Medical		Denna +	. Graham)		January o	20,2004	6.10 AM
xamine		la. Facility Name (If not institution, gi		4b City	y, Town, or Location of Dea	ith /	c. County of Deat	h
		Juseph KIT	chie Hospic	e eu	er 1 Year If Under 24 Hr	S C Court of Birth	NH	- 1 (Ch.)
neral		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Sex 7. Age (In yrs. la 1 ☐ M 2 DF	Yrs. Months			9. Birt	nplace (State or Foreign untry)
ctor	9	Usual Residence of Decedent				Duly 7, 12	00 011	9/1/1/4
item 27 is marked Other tilsan i fatural, or veins 230 of 28st show other traumatic event, the Medical Evanties must be recified at TO Be Completed by Europea Director	Ī	10a. State 10b. County	10c. City	Town or Location				10d. Inside City Limits
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l'e	Funeral Director	10e. Street and Number	CI	10f. Z	ip Code	10g. (Citizen of What Co	untry?
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2	by F	1 Never Married 2 Married 3 1 Widowed 4 Divorced	1 ☐ Yes 2 (PNo If Yes, Give Year or Dates:	1 ☐ Yes	21 No Specify:		Specify:	Iack
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once.	-1	19a. Informant's Name/Relationship	(Type, Print) THP, - Sister	19b. Mailing Addre	ss (Street and Number or F	Rural Route Number, City	y or Town, State, 2	ip Code) 1920
1	-	Darjene Baj	110	ace of Disposition (N	lame of	Date 20c.	Location - City or	Town State
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	1 4 66	metery, crematory of	r other place)	2 n/ /	an colocul	on mi
		'4 □Donation S □Other (Spec		ZIVII CEI	nesery i a	7-04	HOLLEW	00 1000
		21. Signature of Funeral Service Lice	ages /	- Name	and Address of Facility	-/H Bal	to ms	R1250
	-	232 Part Forer the disease or col	polications that caused the death	Do not enter the m	ode of dving, such as cardi	ac or respiratory arrest.	1110	Approximate
		23a. Pant 1. Enter the disease, or con shock, or heart failure. List ont Immediate Cause (Final	y one cause on each line.			,		Interval Between Onset and Death
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		resulting in death) Last	Due to (or as a consequ	ence of):				
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100	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic			23d. Date of del Month	ivery Dav Year
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i	2	. a., ii. Other significant continuous	Commission of the control less	g allo alloonyilly	g comme gerserini i Bitti.	1 ☐ Yes		
	eted					•		tanay findinga ayayahla
8	Completed					24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
						1 ☐ Yes 2 Ø		2 No
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): To	1 Tyes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3☐ 28b. Time of	28c. Injury at Work?	Home 5 ☐ Residence		City) TOSUTCE
- 11.5	ö	1 Natural 5 Pending 2 Accident investigate		Injury M	Work? 1 ☐ Yes 2 ☐ No			
	귤	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At ho		ory, office	28f. Location (Street City or Town, St	and Number or Ru	ıra/ Route Number,
1	ficat	4 T Homiside Uetermine	building, etc. (Specify	/		City of Town, St	aid)	
100000	Sertificati	4 ☐ Homicide			ad at the time, date and ale	ce, and due to the cause	(s) and manner as	stated.
	al Certification:	29a. Certifier 12 Certifying	Physician: To the best of my know	wledge, death occurr	ed at the time, date and pla	ourred at the time date	and along and dire	to the equec(a)
		29a. Certifier (Check only one) (Check only one)	Physician: To the best of my know aminer: On the basis of examinal and manner stated.	ion and/or investigati	on, in my opinion, death oc	curred at the time, date a		to the cause(s)
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			1 - For State Registrar	State of Ma	aryland / Depa	artment of rtificate o			giene 0	04 01440
			1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month	th Day	3. Time of Death
	Physicia		Allen	J.		Hen	son Sr.	Januar		004 12:30a.M
	/Medic Examin		4a. Facility Name (If not institution				, or Location of Deat	h	4c. County	of Deeth
	CXMIIII	Ç.	Joseph Riche	y Hospice		Balt	imore			
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Ye	ar If Under 24 Hrs	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		214-50-1930	XIXM 2□ F	56 Yrs.	Months Day	s Hours Min.		1 47	MD
			Usual Residence of Decedent							
	ylanc		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man- -f st	to	MD NA		Baltimo	re				1X Yes 2 □ No
	rs after death with the Marylan , or items 23a or 28a-f show raminal for nelling at	Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of W	/hat Country?
	3a o		137 North Be	nd Road Ar	ot 2D		21229		U.S	. A .
	leath ns 2	by Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		of Hispanic Origin? (S uban, Mexican, Puen	pecify Yes or No-	14. Race	- American Indian,
	ter c	Fun	1 ☐ Never Married 2 ☐ Marr	Armed Forces? ied 1 ☐ Yes 2 ☑ If Yes, Give	No			to Hican, etc.)		k, White, etc.
38	urs a	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give 22 Year or Dates:		1 □ Yes XX	lo Specify:		Specify	Black
ŏ	2 hou	ed	15. Decedent	's Education	16a. Dece	dent's Usual Occ	cupation		16b. Kind of Bu	siness/Industry
7.	n n	plet	(Specify only highes Elementary/Secondary (0-12)	completed) College (1-4or t	(Give	DO NOT use ret	ne during most of wo ired)	rking		
21215-0036	with iene	Completed	12th grade	3yrs	Enten	tainme	nt Promo	ter	Self E	mployed
0	be filed within 72 ho ital Hygiene. id other than "natui event, tra Medical	0	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	me (First, Middle,	Maiden Surnam	9)
an	id be ental ked c ev	To B	Daniel P. Her	son Jr.			Floren	ce Farm	ner	
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be millied at	-	19a. Informant's Name/Relations		19b. Maili	ng Address (Stre	et and Number or Ru			State, Zip Code)
<u>8</u>	permit. Pages 1 and 2 should Department of Health and Mer Importsnt: If Item 27 is marke any injury or other traumatic once.		Allen J. Hens	on JrSon	n 3718	Kimbl	e Road,	Baltimo	ore Md	21218
150	1 ar Hea Hea Sther		20a. Method of Disposition		20b. Place of Dispo cemetery, cre			Date		City or Town, State
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3al	Depar Depar Impoi		21. Signaturi of Purieral Service	Licerised	M	larch F	/H West			
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	9 3	cal		d						
	leath certificat attending phy I for use as th	Med	IF FEMALE:							
/ Box	h cel endii	7	23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death 3	⊒Ectopic pregna	ncv			of delivery
<u> </u>	deat e att	Cla	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at		Other (specify)			Mor	ith Day Year
20	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	9 Unknown	9CJ ONKHOWN						
CMSOr	w requires tha been signed I should be det	by P	Part II. Other significant condition	ons contributing to death b	out not resulting in the u	inderlying cause	given in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?
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ens.	w rec	Completed	id. nea	tension				24a. Was a	ın 24b. V	Vere autopsy findings available
Re	The lay	m.	- 197	1 1	. 1	4 51 4		autops	med? d	rior to completion of cause of eath? Yes 2 No
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> 0	Phys raidi	-	27. Manner of Death				njury at	28d. Describe h		
on G	ding Pt h. After th funeral	lon	1 ☑ Natural 5 ☐ Pendin		y Year) Injury		Vork? □Yes 2□No			
- 18	deat deat stor: / the	Ica	3 ☐ Suicide 6 ☐ Could	not be age Place of Ini	jury - At home, farm, st	reet, factory, offic	ce	28f. Location (S	treet and Numbe	or or Rural Route Number,
A e	or Att after d Direct in by	Certification:	4 Homicide determ	building, et	c. (Specify)			City or Town	n, State)	
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14	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical		Exeminer: On the basis of and manner st	f examination and/or in					
	t a th	ec	29b. Signature and title of certifie			29c. Lice	ense number	2	9d. Date signed	(Month, Dey, Year)
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•	Vith with To I	2	30. Name and address of person	who completed cause of o	death (Item 23a) (Type,		, ,	and, R	oal	1-0 Lp
	To To Court		30. Name and address of person	who completed cause of c	death (Item 23a) (Type,		824 Win	and, R		1-0 Lg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mon HARRISON ORANCE 30 M 03 2004 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LAND CORRECTIONAL HAGERS Town INSTITUTO 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign 86.8898 100 M 2□ F Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County Town or Location 28a-f show 10d. Inside/City Limits the Mudical Examiner must be notified at AUTIMORE Completed by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ŏ 21202 U.S.A. or frems 23a Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 1 No 3 Widowed 4 Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired)

BUS DRIVER and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 17. Father's Name (First, Middle, Last, Be 18. Mother's Name (First, Middle Maiden Surname) ORANCE WASHINGTON ္က 19b. Mailing Address (Street and Number of Rural, Route Number, City or Town, State, Zip Code) MOTHER permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any injury or other trau BATIMORE, MO 21202 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1:10.04 BATIMORE, MARYLAND MOUNT ZION CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAVEHTN C. GREENE FUNCIAL HOME LORK ROAD BALTIMORE, MO Vaus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** C 2 X ardea /Medical Due to (or as a consequence of): Examiner EUCC 070 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed L Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) certiticate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1□ Yes 2☑ No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the tu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CX 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's gnature

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Hugh F. Hopkins A. Footy Name (if not eachborn give small and number) Howard County General Hoppial Howard County General Hoppial Formation Joseph Samp (if not eachborn give small and number) Howard County General Hoppial To gray in your set in the county of th		8	1 - For State Registrar	State of Maryla		artment of H rtificate of L			iene 200	4 0 1 4 4 2
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Physician Medical Examiner Physician Medical Examiner Physician Medic	Balt permit. Departr importe sny inji		21. Signature of Funeral Service Lic	ensee July MD1993	3	2. Name and Addres Slack 3871 (Funeral Hom Old Columbia	e, P.A. Pike Ellicott	t City, MD 210	43
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Registrar AN 2 2 2004 Miles As Association			31. Date filed (Month, Day, Year)			Boarts)	-0,001	י טועוייע	L.D. XIV	+

		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan	d / Depa		Health an		giene 2 (Property of the state of the st
Physici /Medio Examin	al	Reba Rolen 4a. Facility Name (If not institution, give s Mariner Health at	treet and number)			n, or Location of D Burnie	2. Date of De Month 1	Day 18 20 4c. County		3. Time of Death 9:30 A M
Funeral Director		5. Social Security Number 6. Sex			If Under 1 Ye Months Day	ar If Under 24	8. Date of Bir (Month, Da 6-4-190		9. Birthp Coun	lace (State or Foreign try) TN
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In the Maryland in Merked other than "natural" or items 23a or 28a-f show umatic event, the Madical Exeminer main be notified a	Director	MD Anne Arun 10e. Street and Number	del G1	y, Town or Lo en Bur	nie 10f. Zip Cod			10g. Citizen of \	What Coun	0d. Inside City Limits 1 ☐ Yes 2 1 No
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		State of Maryland / De State of Maryland / De Registrar 1. Decedent's Name (First, Middle, Last)	Timodio of Dodin	2. Date of Deat		3. Time of Death
Physici		Abuda	Jackson	Month JANUARY	Day Yeer	
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deet	
		UNION MEMORIAL HOSPITAL	BALTIMORE CITY			
Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthda 21 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 08 2.	9. Birth Co.	nplece (State or Foreign untry) MD
land W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
Maryland -fehow lied al	tor	MD NA Baltin	nore			1 X
or 284	lrec	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	untry?
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or its	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Nover Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes X No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: B1	
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a la la la la la la la la la la la la la	To Be	Early Jackson		Robert	•	
Maryic			ling Address (Street and Number or Ru			ip Code)
the search		20a. Method of Disposition 20b. Place of Discometery, circles and the second of Disposition 2 □ Cremation 3 □ Removal from State	ematory or other place)	Date 2	20c. Location - City or 1	
Defilition permit. Pages Department of P Important: If its eny Injury or of		21. Signature of Funeral Service Licensee	on Cemetery 1/23 22 Name and Address of Facility 1arch F/H West 1300 Wabash Ave		Baltimore more Md	21215
=4 4		23a. Parl 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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To the Hospital or Attendi within 24 hours after death. To the Funeral birector: A completely filled in by the fu	edical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place	Baltimore, and due to the cau red at the time, dat	uso/s) and manner as a	stated. to the cause(s)
To the within: To the comple	Mec	29b. Signature and title of certifier Mallyrie The Should by	29c. License number		d. Date signed (Month, JANUARY 1	Dey, Year) 8, 2004
		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 1 Penn Street, Ba			

DHMH 17 Rev 1/2001

ORIGINAL

		Registrar 1. Decedent's Name (First, Middle, Last	Mara Jef		rtificate d	Douin -	2. Date of D	Reg. No.		3. Time of Death	
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Medic: camine		4a. Facility Name (If not institution, give	street and number)		4b. City. Tow	n, or Location of Dea		4c. C	County of Death	11.20	
.amm		The Johns He	opkins Hos	nital	7	more	City	1	TIMORE (CITY	
eral		5. Social Security Number 6. Se	x 7. Age (In yrs	last birthday)	If Under 1 Ye	ear If Under 24 Hr	S. B. Date of B	irth	9. Birth	place (Stete or Foreign	
ctor		220-67-3301	DM 2 ² €F 0	Yrs.	Months Da	ys Hours Mir	n. (Mohth, L	Day, Year) 1. 200	MAR	YLAND	
		Usual Residence of Decedent					-140-A = -T				
lical Examiner was be notified at	_	10a. State 10b. County		ity, Town or Lo						10d. tnside City Limits 1 ☐ Yes 2 No	
il i	Director	MARYLAND ANNE A	RUNDEL G	LEN BU							
2		10e. Street and Number 8035 GREENLEAF TER	RACE APT. 13		10f. Zip Cod 2106				en of What Coul ED STATI	•	
	B		12. Was Decedent Ever in				Caast. V				_
	Š.	11. Marital Status 1 ☒Never Married 2 ☐ Married	Armed Forces?	J.S. 13.	If Yes, specify (of Hispanic Origin? (Suban, Mexican, Pue	specify Yes or N into Rican, etc.)	10-	I. Race - Americ Black, White,		
	by	3 Widowed 4 Divorced	tf Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specify:		S	Specify: WH	ITE	
	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation		16b. Kind	of Business/In	dustry	-
	pie	(Specify only highest grad	e completed) Coltege (1-4or 5+)	life.	NOT use re	ne during most of wi tired)	orking				
	Completed	0		INF	ANT			N/A	A		
	Be	17. Father's Name (First, Middle, Last)					ame (First, Middl	e, Maiden St	umame)		
	2	JEFFREY D. KNOX				LISA M	. BOGGS			<u></u>	
		19a. Informant's Name/Relationship (7) JEFFREY D. KNOX -	• •			eet and Number or F EAF TERRA					ď
				-						IE, MARYLAN	
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	osition (Name or matory or other	place) OAN	UARY 23		ation - City or To		
	-	'4 □ Donation 5 □ Other (Specify)		N HAVE	N MEM.	PK. 200	4	GLEN E	BURNIE,	MARYLAND	
once.		21. Signaturi of Fureral Service Licens		4	TRKLEY 21 CRAI	KÜDÖĞÇİY FI N HIGHWAY	UNERAL H S.E. GI	OME BUI	RNIE, ²¹	061 ARYLAND	
		23a. Part1. Enter the disease, or compt shock, or heart failure. List only or	ications that caused the dea	th. Do not en	er the mode of	dying, such as cardia	ac or respiratory	arrest,		Approximate Interval Between	
an		Immediate Cause (Final disease or condition	Sepsis							Onset and Death	
al		resulting in death)	Due to (or as a conse	quence of):						1)1.	-
r		Sequentially list conditions			tache	art dis	ease.	stat	45 Yost	amos.	
	ine	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quende of):	1	1 1	ortic				
	Examine	that initiated events resulting in death) Last	Due to (or as a conse	the IU.	te rru	pted a	0179	arci			_
			200 10 (0) 43 4 00/130	querice or).							
	dicai		1								-
	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregr	ancv				226	d. Data of dalling		
	clar	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	at death 3	Ectopic pregna Other (specify			230	d. Date of delive Month	Day Year	
	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		2 0 11 01 (5 0 0 0 11)	/					
l i	by Pr	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?	ı
							1 🗆	Yes 28	No 3∏Prob	ably 4 Unknown	Į
	iete						24a. Wa	s an 2	24b. Were auto	psy findings available	
	Completed						auto perf	opsy ormed?	prior to cor death?	impletion of cause of	
- 112	e e	25. Was case referred to medical				26 Place of De	ath (Check only	2 No	1 ∐ Yes	2X No	-
	10 B	examiner? 1 ☐ Yes 2 ☐ No	lospitat: 1 X npatient 2 [ER/Outpatier	at 3 DOA	O#	Home 5 ☐ Res		Other (Seaso)		ĺ
		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		njury at Vork?	28d. Describe			0	
	at lo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Intury		Vork? □Yes 2□No					
	2	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office	ce	28f. Location	(Street and N	Number or Rura	I Route Number,	
	Certification:		Į.					wn, State)			
	edical	29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the vestigation, in m	e time, date and plac y opinion, death occ	e, and due to the urred at the time	cause(s) an date and pla	nd manner as st ace, and due to	ated. the cause(s)	
	ĕ -	29b. Signature and title of certifier	Stated.		29c. Lice	ense number		29d. Date s	signed (Month, I	Dev. Year)	-
			(1		RC	23239	79	Ta	202	2004	-
		30. Name and address of person who co	impleted cause of death (the	m 23a) /Tuna	Print)		/	Jun	. 20	2004 more MO 21287	1
			cosson, By		36. J	Thus Hope	Kins Ho	spital	, Balti	more, MD	-
			1 . 7 . ,		- /			v	,		

DHMH 17 Rev 1/2001

ORIGINAL

	1 - For State Registrar	State of Mary		artment of H rtificate of L		R	eg. No.	01	1, 1, 6
Physician /Medical	Decedent's Name (First, Middle, I. RUI	BIN		KURYK		2. Date of Deal Month JANUAR	Y 18, 2		P M
Examiner	4a. Facility Name (If not institution, g 4730 ATRIUM COU				GS MILLS		4c. County	of Death LTIMORE	
Funeral Director	5. Social Security Number 6. 215-12-5893	Sex 7. Age (In	n yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV. 18	, 1920	9. Birthplace (State of Country) MD	or Foreign
Maryland f show	Usual Residence of Decedent 10a. State 10b. County MD BAL	TIMORE 10	C. City, Town or Lo	cation NGS MILLS				10d. Inside C	
ath with the Marylar 23s or 28s-1 show wat be mailified at ral Director	10e. Street and Number		01111	10f. Zip Code		1	0g. Citizen of W		
of the death with the remark that the remark	4730 ATRIUM COU	JRT #479	rin II S 13 V	Was Decedent of Hi	21117	ocity Vas or No-	14 Race	U.S.A	•
illed within 72 hours after death with the Maryland Hygiene. Hygiene, Hygiene, or items 23a or 28a-f show ont, the Maryland Examiner must be notified at Completed by Funeral Director	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1	f Yes, specify Cuba □ Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)		k, White, etc.	
ed within 72 hours ygiene. ner than "natural", it, the Moucal Exi Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, PRIETOR	furina most of worki	ng	16b. Kind of Bus		
D S d is D	17. Father's Name (First, Middle, Last BENJAMIN	2	KURYI		18. Mother's Name	(First, Middle, A	DRY CLI		E
s 1 and 2 should f Health and Mer Item 27 is marke other traumatic	19a. Informant's Name/Relationship WENDY MATHIAS /	DAUGHTER	214 N	MAPLEWOOD	nd Number or Rura ROAD - H				
Page nent o ant: If ury or	20a. Method of Disposition 1	Musilia al II alla al II	Place of Dispo- cemetery, cren LIBERTY			/2004		City or Town, State	MD
permit. Departimonts any inju	21. Signature of Funeral Service Lic	ensee		Name and Addres	30		SON & BI	ROS., INC. LE, MD 21	
Physician /Medical Examiner	23a. Part1. Enter the lise se, or co shock, or heart failing. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the yone cause on each line. a. Due to (or as a co	death. Do not ente		g, such as cardiac o		est,	Approximate Interval Bette Onset and It	e ween
in the second se	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dus to (or as a co							•
ysicia ne bui	resulting in death) Last	Due to (or as a co	nsequence of);						
ath certif	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Y	'ear
quires that the de in signed by the a uid be detached f	Part II. Other significant conditions	contributing to death but no	ot resulting in the un	iderlying cause give	n in Part I.			bute to the cause of d	eath? Inknown
: The law requir cate has been si page 2 should I						24a. Was an autopsy perform	pr led? de	ere autopsy findings a for to completion of calent?	
hysician this certifi Il director	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Other	26. Place of Death 7. 4 ☐ Nursing Hom		1	ASSI:	100000000000000000000000000000000000000
To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be director. Medical Certification: To Be Completed by	27. Manner of Death 1. Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Yea		28c. Injury Work		8d. Describe how			ING
ital or Attending Pris after death. Tal Director: Attert led in by the funera	3 Suicide 6 Could not 4 Homicide determine	building, etc. (S)	pecify)			City or Town,	State)	r or Rural Route Numi	ber,
To the Hospital within 24 hours a To the Funeral I completely filled	one) 2 Medical Exa	hysician: To the best of my iminer: On the basis of exa- and manner stated.	knowledge, death mination and/or inv	estigation, in my op	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	use(s) and man te and place, ar	nar as stated. nd due to the cause(s)	
To To to to to to to to to to to to to to to	29b. Signature and title of certifier	n Lalle	em'	29c. License	number	29	d. Date signed	(Month, Day, Year)	
10	30. Name and address of person who	completed cause of death	(Item 23a) (Type, F	Print) PARK	HEIGH	TS AVE	BA	EDMD21	208
State Registrar	31. Date filed (Month, Day, Year)	2 2004 Registrar's S	Signature A	poli					

			1 - For State Registrar	State of Maryland / D	Department of H		ental Hygie	_ / !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	01447
	Physici		1. Decedent's Name (First, Middle, Last)	- A. Leach	Jr		2. Date of Death	Day Year ZOU	3. Time of Death 5.00 PM
	/Medio Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or	Location of Death	J Wit.	4c. County of Death	7
	Funeral Director		270-10-1700	IN OUT 10			B. Date of Birth (Month, Day, Ye NOVEWBEL		lace (State or Foreign try)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			11	0d. Inside City Limits
	th with the 23a or 28e	al Director	10e. Street and Number	street	10f. Zip Code 2 / 2	-17	10g.	Citizen of What Coun	try?
5-0036	be filed within 72 hours after death with the Maryland tial Hygiene. tal Hygiene. d other than "naturel", or items 23a or 28e-f show event, the Medical Examinar must be indiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 □ ★es 2 □ No If ¥es, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - America Black, White, e	an Indian, etc.
1215	d within 72 ho giene. ir thsin "natui the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind of work done di life. DO NOT use retired)	uring most of working	7	. Kind of Business/Ind	
and	ild be filed lental Hygid ked other ic event, I	Be	17. Father's Name (First, Middle, Last)) <		18. Mother's Name (First, Middle, Maid	den Sumame)	
Ĕ	d 2 shouth and M 7 Is mar treumat	To	19a. Informant's Name/Relationship (Typ.	po, Print) daughter 196.	Mailing Address (Street as	Muggie nd Number or Rural I we Ave 1			Code)
Ö	- I 5 5	3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Gramation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Disposition (Name of c, crematory or other place) Junuary	te 20c.	Location - City or Tox	wn, State
Balti	permit. Pages Department of Importent: If it eny injury or o once.		21. Signature of Funeral Service License	0	22. Name and Address	-	L38	B N. Gilm	n St
	nysician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Cations that caused the death. Do not e cause on each line. Due to (or as a consequence of	n pre	such as cardiac or r			Approximate Interval Between Onset and Death
	led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):				
8/60,	certificate be executed ding physician and use as the burial-transit	dical	that initiated events resulting in death) Last	Due to (or as a consequence of	f):				
Ď	atter for t	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliver Month	y Day Year
cords, P	w requires that the debase signed by the should be detached	ру Р	Part II. Other significant conditions conf	ributing to death but not resulting in t	the underlying cause giver	in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
l Kec	ate has	Completed	Cirrhosis	of liver; clt.	pulmerung	J. Seas E	24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
VITAL	rnysictent. The this certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	ospital: 1 ⊠'Inpatient 2 □ ER/Outp	Othor	26. Place of Death (C	Check only one)	6 ☐Other (Specify)	
	After th		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin	me of 28c. injury a work?	at 280	d. Describe how in		
	within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f	Location (Street : City or Town, Sta	and Number or Rural ate)	Route Number,
	within 24 hours after	edical	29a. Certifier (Check only one) Certifying Physical Scaming Physical Physical Scaming Physical	cien: To the best of my knowledge, of er: On the basis of examination and/of and manner stated.	death occurred at the time or investigation, in my opir	, date and place, and nion, death occurred	d due to the cause at the time, date a	(s) and manner as stated and place, and due to t	ted. he cause(s)
	within To th	M	29b. Signature and title of certifier		29c. License		1	Date signed (Month, Da	ay, Year)
4)		30. Name and address of person who con	apleted cause of death (Item 23a) (Ty	ype, Print)	15698	211-	ma de	1223
			31. Date filed (Month, Day, Year)	C/A, My 13 or	- Toro Missis	557.7x1,	Dal Time	VE IVICO. 2	1225

DHMH 17 Rev 1/2001

Registrar

	1 - State Registrar	Property of the second				artment rtificate			ario ivi		Reg. No.	201	1	
nysician Medical			Erna Let	as						2. Date of De Month	Day		90 r	3. Time of Death
xaminer neral	4a. Facility Name (If no St. Agr	tes 1-1	sex 7.	•	st birthday)	4b. City, To	-1+	Location of	24 Hrs.	8. Date of Bir	rth	9	/A Birthpfa	ace (State or Fore
ector	216-74-064 Usuel Residence of De 10a. State 10	10	1□ M ¾(XF	94	Yrs.		Days	Hours		Jul. 8,	190	9		71and
be notified at Director		Balti	more	Toc. City,	Town or Lo	Caton		le_						d. Inside City Lim
al Dir	10e. Street and Number 713 Maider		e Ln., Ap	t 2113		10f. Zip C	212	28				zen of Wha ited		•
ovent, the Mulical Examiner must be notified at Be Completed by Funeral Director	3 ₩Widowed 4 [12. Was Decede Armed Force 1 Tes 2 ff Yes, Give Year or Date	™ No	1	Was Decede f Yes, specif 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		4. Race - A Bfack, V Specify:		tc.
vent, the Medical E	(Specify Elementary/Seconda		Education rade completed) College (1-4	or 5+)	(Give life. l	dent's Usual kind of work DO NOT use nemaket	done du retired)	tion uring most	of workin	99		od of Busin		ustry
matic event, To Be C	Rudolf Sch	naefer						Fı	rieda	(First, Middle,	, Maiden :	Sumame)		
ar traum	19a. Informant's Name Joan Ai					ng Address (Route Number minste			te, <i>Zip (</i> 1157	
ry or othe	20a. Method of Dispos 1 M Burial 2 □ C	Premation 3 [☐Removal from Sta	110	netery, crem	sition (Name natory or oth irk Cei	of er place)		ate	20c. Loc	ation - City	or Tow	m, State
any injury or other traumatic as once.	21. Signature of Funer			+MC	22	. Name and	Address	of Facility	Ambro	se Fun	eral	Home	, Ir	nc.
ician dical	23a. Part 1. Enter the of shock, or heart far Immediate Cause (Fin disease or condition resulting in death)	alture. List only	one cause on each	sed the death.						respiratory a				Approximate nterval Between Onset and Death
the burial-transit			c	as a conseque										
should be detached for use as t	IF FEMALE: 23b. Was decedent print in the past 12 mo 1 □ Yes 2 N N 9 □ Unknown	nths?		2 ☐ Fetel d t at time of dea	leath 3	Ectopic preg					2:	3d. Date of Month	,	/ Jay Year
should be deta	Part II. Other significal	nt conditions	contributing to deati	h but not result	ing in the ur	nderlying cau	ıse giver	n in Part I.			obacco us Yes 2		e to the	cause of death?
. page 2 should										24a. Was autop perfo 1 Yes		24b. Were prior death	to com	y findings availa pletion of cause
completely filled in by the funeral director, page 2.8 Medical Certification; To Be Compi	The state of the s										(pecify)			
led in by the funera	3 ☐ Suicide 4 ☐ Homicide	Could not be determined	28e. Place of	fnjury - At hom etc. (Specify)	ie, farm, stre	eet, factory, o	office		28	Bf. Location (S City or Ton		Number or	Rural F	Poute Number,
Medical	one)	_ Medicei Exa	nysicien: To the be miner: On the basis and manner	s of examination	edge, death in and/or inv	occurred at restigation, in	the time n my opir	, date and nion, death	place, ar	nd due to the d d at the time, d	cause(s) a date and p	ind manner place, and o	as stat	ed. ne cause(s)
E 2	29b. Signature and title	of certifier	Λ.	10		29c. L	License		4			signed (Mo		
0	30. Name and address	22	1, 10	112		D) 2,	8+1	07		Jan	racy	18	,2001

1-00551 PD			/land / Depa	artment of Health and rtificate of Death	Mental Hygi	_	and the same
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) CHANTAL Facility Name (If not institution, give street and number) Greater Baltimore Medical Ce	R.	LOOMIS 4b. City, Town, or Location of Dea TOWSOD	2. Date of Death Month January	Day Year	
Funeral Director			n yrs. last birthday) 27 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min			place (State or Foreign intry) MD
hours after death with the Maryland hours after death with the Maryland tural; or Items 23a or 28s-f show at Examiner must be notified at	Director	NY MANHATTAN 10e. Street and Number	MANH	ATTAN 10f. Zip Code	100	g. Citizen of What Cou	10d. Inside City Limits 1
be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene do other than "natural", or items 23a or 28a-f ehow event, it a Medical Examiner must be notified at	by Funerai	41 W. 96TH STREET #2-A 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 42 Was Decedent Ever		10025 Was Decedent of Hispanic Origin? (\$f Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
d within 72 giene. or than "nal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	lent's Usual Occupation kind of work done during most of wo DO NOT use retired) DENT / DESIGNER	rking 16	6b. Kind of Business/Ir	ndustry
d 2 should be filed in and Mental Hygin 7 is marked other traumatic event,	To Be (17. Father's Name (First, Middle, Last) LAWRENCE 19a. Informant's Name/Relationship (Type, Print)	LOOM:			iden Sumame)	COHEN
s 1 and 1 tem 2 te		1 Burial 2 Cremation 3 X Removal from State	1130. Ob. Place of Disposemetery, crem	1 BUCKLEBERRY PAT sition (Name of natory or other place)	TH - COLUM	BIA, MD 21 c. Location - City or T	044 own, State
permit. Pages 1 al Department of Hea Importent: If Item eny injury or othe		21. Signature of Funeral Service Licenses	- 22	Name and Address of Facility S	SOL LEVINS N ROAD - P		, INC.
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Har	er the mode of dying, such as cardial	c or respiratory arrest	t.	Approximate Interval Between Onset and Death
cia De	cai Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a co					
nding phuse as th	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No Unknown 23c. If yes, outcome of principle in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year
v requires ti been signe should be c	ompieted by P	Part II. Other significant conditions contributing to death but no	t resulting in the un	derlying cause given in Part I.	23e. Did tobac 1 ☐ Yes 24a. Was an		ne cause of death? ably 4 Unknown psy findings available
Physicien: The law this certificate has braid director, page 2 st	BeC	25. Was case referred to medical examiner? Hospital:		Other	autopsy performer 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	d? prior to co death? No 1 ☐ Yes	mpletion of cause of
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification; To	27. Manner of Death 1 □ Natural 2 □ Accident 3 □ Squicide 4 □ Homicide 1 □ Notural 5 □ Pending investigation 6 □ Could not be determined 2 □ Squicide 4 □ Homicide 1 □ Inpatient 28a. Date of Injury Month, Day Yes 2 □ No 28a. Date of Injury Month, Day Yes building, etc. (S)	At home, farm, stre	28c. Injury at Work? M 1 Yes 2 To No	28d. Describe how 28f. Location (Stree City or Town, S	at and Numb r or Rura	e f I Route Number,
To the Hosp within 24 hou To the Funel completely file	Medical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner stated. 29b. Signature and title of certifier	knowledge, death mination and/or inve	occurred at the time, date and place estigation, in my opinion, death occu 29c. License number	rred at the time, date	e(s) and manner as si and place, and due to Date signed (Month,	the cause(s)
0	The state of the s	30. Name and address of person who completed cause of death J. LA LON LOTE, MO	1	O.C.M.E. 11 Penn Street,		anuary 20, Maryland	
Stat Registra	ır	31. Date filed (Month, Day, Year) 32. Registrar's S JAN 2 2 2004	signature	both			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22/04 tas Certificate of Death State Registrar Amend Item #23824a per phy G827 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 08 0 2004 /Medical 4c. County of Death Town, or Location of Death 4a. Fecility Name (If not institution, give street and Examiner)(5 I Under 24 8. Date of Birth (Month, Day, Year) 19 23 3 Birthplece (State or Foreign Country)
 SC 5. Social Security Number 6. Sex (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 71 Yrs. 09 215-34-8024 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-1 ehow ral', or Itame 23a or 28a-f ehov Examiner must be notified at XXYes 2 □ No Director Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1800 Hollins Street Apt 316 21223 Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Ilmany or other traumate. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify Black Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Help Aid 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Mae McWhite 2 Hezekiah Shird 19b. Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Code)
5632 University Village View
Colorado Springs, C 80918 19a. Informant's Name/Relationship (Type, Print) Susan Harvey-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Garrison Forest Vet. 1/16/04 Owings Mills, March F/H West of Funeral Service Licedses 21. Signature 21215 4300 Wabash Baltimore Md Ave, Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. tmmediate Cause (Final **Physician** resulting in death) /Medical a consequence Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by g 1 ☐ Yes 2 No 3 Probably 4 □Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy has page 2 2X No certificate 1 ☐ Yes 25. Was case reterred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes Inpatient this filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 1 Natural
2 Accident (Mo Injury Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury 28f. Location (Street and Number or Rural Route Number, City or Town, State) At home, farm, street, factory, office 4 Homicide building, etc. (Specify) ö Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the s License number 29d. Date signed (Month, Dey. Year) 29b. Signature and title of certifier ္ moteted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

an organization

32. Registra Signature

2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Sh 5.00 Yn Danharn 2004 Raymond Douglas Mullis 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arundal Burnia HO5171 6. Sex 1 M M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (În yrs. last birthday) Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Months Hours Yrs. 214-24-6092 77 July 17, 1926 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1047 Springhill Way 21054 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 1944–46 Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Boiler Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Henry Mullis Mary Douglas Dew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Carolyn E. Mullis/Wife 1047 Springhill Way Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 1/24/04 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. uanita nomas M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral Directo

Be Completed by

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be incitified at pine.

Examiner Physician/Medical Completed by has director, Be Certification: To this

The law requires that the death certificate be executed

Vital Records, P.O. Box 68760

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Attending

Hospital

after ō

Director: A

within 24 hours a

To the Funeral C

completely filled filled

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State

Registrar

29a. Certifiei (Check only

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No

25. Was case referred to medical examiner? Hospital: 1 Tyes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 1- Natural 5 Pending

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

4800

investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

BOVA 30

31. Date filed (Month, Day, Year) 32 Registrar's Signature JAN 2 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar Amend Item #9&18 per fh G82 Pertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Day Mont **Physician** /Medical 4b. City, Town, or Location of Death Examiner HOME 9. Elyppatelistaleanfordoina Social Security Number **Funeral** Min. Director filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan ment of Health and Mental Hygheins anti-tiffering 21 is marked other than "naturel", or tame 23a or 28a-f show ury or other traumatic event, the Medical Exam has mattle to notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: Blac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) dary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be S Artense Curry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Baltimore, 20c. Location - City or Town, State Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 900ce. 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Physician/Medical Examiner anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy 1 Live birth Year jo in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2□ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 □ Inpatient Other: ို 1 Tes 2 Visio 2 ER/Outpatient 3 DOA 4 Sing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause death (Item 23a) (Type, Print) ORETHIN AMBACHEN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Oay, Year)

32. Registra Signature

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To the within 2	comple	29b. Signa	ture and file of ce	ortifier (2_	·~>		29c. Licen:	8303		29d. Date sign	. 2	
_	8	30. Name	and address of pe	rson who co	mpleted caus		m 23a) (Type.			Berttin	ore in		
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			Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	3. Time of Death		
	Physicia /Medic	al	ABRAHAM	MAKOFS				January	20, 2004	3:00A M		
	Examin	er	4a. Fecility Name (If not institution, give s Broadmead			4b. City, Town, or Cockey	sville		4c. County of Deat Baltimo	re		
	Funeral Director		5. Social Security Number 6. Sex 117-05-4224		ge (In yrs. last birthda) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day November 9	9. Birth 1913 New	nplace (State or Foreign untry) YONK		
	land ow		10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits		
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980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Evaninae must be inclided at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' XXYes 2 If Yes, Give Year or Dates:	No WWII	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XX No	Specify:	o Rican, etc.)	Black, White	e, etc.		
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Maryland 21215-0036	and and sem		19a. Informant's Name/Relationship (Ty Judith Tanzer	рө, Print) DTF		-			; City or Town, State, 2 W York 139			
	ges 1 and 2 t of Health If Item 27 or other tru		20a. Method of Disposition		20b. Place of Dis				20c. Location - City or			
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Baltimore,	permit. Pag Department Important: I any injury o		21. Janature of Funeral Service Licens	nKen	rka				Mefeld Funeral More, Maryl			
			23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause ne cause on each	ed the death. Do not e line.	nter the mode of dyin	g, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death		
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8760,	ate be executed hysician and the burial-transit	dlcal Ex		Due to (or a	s a consequence or,							
9	ificate g phys as the	edic		J								
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	B □Ectopic pregnancy i □ Other (specify)			23d. Date of del Month	ivery Day Year		
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Records,	The law require ate has been si page 2 should I	Completed						24a. Was a autops perform	ned? prior to death?	itopsy findings available completion of cause of		
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of Vital	Physician: this certificatal director,	2	1 Yes 2 No	lospital: 1 ☐ Inpai	1 Inpatient 2 EH/Outpatient 3 UOA 4 Mainsing Home 5 Hesidence 6 Other (Specify)							
ono	ding F h. After funera	tlon	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	jury 28b. Time Day Yeer) Injury	Wor		28d. Describe no	ow injury occurred			
Division	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	of be and Injury. At home form street factors office.						ural Route Number,		
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	10		30. Name and address of person who co	MIDIMP	f death (Item 23a) (Typ	e, Print)	coche	exsulle	y Z LO	30		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2 2 20 Regis	strar's squature	de Sport	20					

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			1_ For State	State of Ma			lealth and Me	ntal Hygier	ne 2001	01455
			Registrar		C	ertificate of		Reg. I	No.	- 1 1 1 G 1
	Physic	ian	1. Decedent's Name (First, Middl	i, Last)	NKM	aht	2	. Date of Death Month	Day Year	3. Time of Death 730 A M
	/Medi		4a. Facility Name (If not institution				r Location of Death		4c. County of Dea	
	Exami	ner	na a -	hmond 1	Ave	Bal	Timor	-1 Pa	4c. County of Dea	ın
	Funeral		5. Social Security Number		(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign
	Director		250-79-7999 Usual Residence of Decedent	10 M 212 F	58 Yrs.			5-/18	45 Sou	
3	yland		10a. State 10b. County		10c. City, Town or	Location	0.1			10d. Inside City Limits
1	e Mari	ctor	Mol.		Balt	IMORE	2 City			1 Yes 2 No
•	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Exeminer may be multified at	Funerai Director	10e. Street and Number	1 200 - 0 4	1-20	10f. Zip Code	1,2	10g.	Citizen of What Co	untry?
	death ms 23	erai	11. Marital Status	12. Was Decedent Ev	ver in U.S. 15			V Yes or No-	14. Race - Ame	rican Indian
9	or iter	표	1 ☐ Never Married 2 Marri	Armed Forces? ied 1 ☐ Yes 2 ☑ No			lispanic Origin? (Speci an, Mexican, Puerto Ric	can, etc.)	Black, Whit	e, etc.
21215-0036	72 hours after natural, or ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: B	acK
15-(natu edica	iete	15. Deceden (Specify only highe	's Education it grade completed)	(Gir	edent's Usual Occup ve kind of work done of DO NOT use retired	during most of working	16b.	Kind of Business/	Industry
12	12 should be filed within in and Mental Hygiene. I is marked other than "raumatic event, the Max	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	.)	Domes	<i>t</i> 1	1	tome n	naker
	e filed Il Hyg othe	BeC	17. Father's Name (First, Middle,	Last)			18. Mother's Name (F	irst, Middle, Maid	en Sumame)	
/lar	Wenta Menta rrked	ToE	Lem Jun	_			Odess	2 To	nes	
Maryland	2 sho and ls mu		19a. Informant's Name/Relations	nip (Type, Print) Det ug	nter 196. Ma	iling Address (Street	and Number or Rural F	// // -	or Town, State, 2	Tip Code)
77.5	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once.		DeLores Ta	nynes '	20b. Place of Dis	Docution (Name of	ich Mor	100 H2	e Bal	to Md.
Baltimore,	nt of I		1 Burial 2 Cremation		cemetery, cr	ematory or other plac	1/24	1/0xL 5	Location - City or	C ² C ²
Ħ	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (S 21. Signature 15 = real Section		Fbenze	R TRESS The 22. Name and Adres		107 30	1620 A	2000 1 11000
B	permit. Departr Imports any inji		Mulphy	Phllix	-	Millers	Me Hopelila	in Chap	el Ba	Ho. N.d.
Ţ.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the	he death. Do not e	nter the mode of dyin	g, such as cardiac or re	espiratory arrest,	-	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Meta		reast Ca	ranoma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a						
		P.	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	consequence on:					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	e be executed rsician and e burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical		d						
89 x	death certificate t attending physic I for use as the t	/Med	IF FEMALE:	222.16				-		
Вох	attend for us	sian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetel death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
P.O.	that the death ed by the atte detached for	Physician/Medi	1 □ Yes 2 No 9 □ Unknown	9 Unknown	me or death 5	Other (specify)				
	s that ned b		Part II. Other significant condition	ns contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
of Vital Records,	w requires that s been signed t should be det	Completed by	Cor pulmoni	.le				1 🗆 Yes	2 XNo 3□Pr	obabły 4 Unknown
ecc	has be	piet						24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
= R	The L	Corr						performed?	death?	_
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	No control			26. Place of Death (C	check only one)		
of	8 V F	2	1 ☐ Yes 2 No 27. Manner of Peath	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatio		4 Nursing Home			ify)
	ding After fune	tion	1 Alatural 5 Pendin 2 Accident investig	(Month, Day)	Year) 28b. Time Injury	Work	at 280 (? /es 2 □ No	l. Describe how inj	ury occurred	
Division	or Atteno after death Director: in by the	ifica	3 Suicide 6 Could r	ot be 28e. Place of Injury	y - At home, farm, s			Location (Street a	and Number or Ru	ral Route Number,
Ö	tel or rs afte el Dir	Certification:	4 - Homicide	building, etc.	(Бреспу)			City or Town, Sta	fe)	
X	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medicai	29a. Certifier (Check only one)	Physician: To the best of examiner: On the basis of ex	xamination and/or i	ith occurred at the tim	e, date and place, and sinion, death occurred a	due to the cause(at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner state	od.	29c. License			ate signed (Month	
	- s - ŏ		1							
	1 0		30. Name and address of person	who completed cause of dea	ith (Item 23a) (Type	p, Print)		Jak	nuary =	,
			Eric L. Nue	unberger mo),	1593 E.J	efferson Str	cet, Bal	tomore a	,2004 1D 2123/
	Sta		31. Date filed (Month, Day,	2 2 200 Registrar	Signature	D Ac	acked		7	

			1 - For State Registrar	State of Maryla		artmen rtificat			and M	R	eg. No.	04	0	155
	Physici	an	1. Decedent's Name (First, Middle, Last)			MUCN	T C IZ			2. Date of Deat Month JANUARY	Day	Year	3. Time o	
	/Media		BEATR] 4a. Facility Name (If not institution, give s			MUSN 4b, City		Location o	of Death	JANUARY	18, 20	004	3:43	3 P M
	Examir	ier	MILFORD MANOR NURS				LTIM		, Dout.		BALT	•		
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birth Month, Day, MAR . 25			place (State	or Foreign
	Director		218-18-8440	M 2 F	79 Yrs.	I I				MAR.25	.1924			1D
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. Inside C	City Limits
	a-fet	ctor	MD BALTIN	10RE	BALT	IMORE							1 🗆 Yes	2 No
	ier death with the Marylan items 23a or 28a-f ehow iter must be notified at	Director	10e. Street and Number			10f. Żip	Code			1	0g. Citizen of	What Cou	ntry?	******
	eath v	erai	4204 OLD MILFORD	MILL ROAD 12. Was Decedent Ever in	118 12	Was Decad	lant of Lie	2120		arity Was as No	14 Pa		U.S.A.	
9	or item	Funeral (1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 M No				n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ck, White,		
003	in 72 hours after death with the Maryland "natural", or items 23a or 28a-1 show tedical Examinat mant be notified at	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Yes 2	2 💢 No	Specify:			Specia	fy:	WHITE	
15-	c • @	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usua kind of wor DO NOT us	k done di	urina most	of worki	ing	16b. Kind of E	lusiness/In	dustry	
212	with that	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		KEEPEI					KITCHE	N CA	BINFTS	
멸	be filed ital Hygi of other event, I	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, N				
yla	should be nd Mental marked umatic ev	인	MORRIS		MILLI				ECCA				KOWITZ	
Maryland 21215-0036	2 a . a		19a. Informant's Name/Relationship (Type BLANCHE FINE / SIS							I Route Number.			Code)	
	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b							20c. Location		own, State	
Ш	Pages nent of ant: If it ary or o	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)							/2004	BAI	TIMO	RF. MI)
Baltimore,	permit. Pag Department Important: any injury once.		1 ABurial 2 Cremation 3 Removal from State										INC.	
	g ∪ ≥ g o		Haw In	amer	89	900 RE	EISTE	RSTO	WN R	OAD - PI	KESVIL	LE, I	MD 212	
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	to /	le	or dying	such as o	cardiac o	r respiratory arre	st,		Approximation interval Bet Onset and	tween
ė.	Examiner			Due to (r as a cons	equency of:	7	ch	400	7+	ran .				
	100	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		equence of):			,		6				
	ecuted ind transii	Examiner	that initiated events C	_ /re	enal	1-	-4	1 / W	P					
8760,	cate be executed bhysicien and the burial-transit	ai Ex	resulting in death) Last	Due to (dr as a conse	equence of):	2		th-	me	b				
687	ficate physics to the	edica	d.	1-4	/ / W P									
Вох	death certificate be executed e attending physicien and od for use as the burial-transit	M/U	230. Was decedent pregnant	3c. If yes, outcome of preg		1					23d. Da	te of delive	ery	
P.O. B	that the death certific ed by the attending p detached for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pre Other (spe					Мо	onth	Day '	Year
Vital Records, F	es ti igne be c	by	Part II. Other significant conditions cond	To Ma	esulting in the un	ndertying ca	iusa giver	in Part I.			acco use cont		ne cause of cably 4 🗆	
eco	ne law re has bee ge 2 sho	Completed								24a. Was an		Were auto	psy findings	available
<u>~</u>	: The cate h	Соп								autopsy perform 1 Yes 2	ed?	death?		ause or
	sician: Th certificate rector, pag	Be	25. Was case referred to modical examiner?	ospital:			Other	100		(Check only one				
of	Attending Physician: r death. sctor: After this certifice by the funeral director.	n: To	27. Manner eath	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of		Ic. Injury a Work?	4 Thurs		ne 5 Resider			<i>'</i>)	
ion	ttending death. stor: Aft the fun	atio	1 Tatural 5 Pending investigation	(Month, Day Year)	Injury	М		s 2□N						
É	al or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At building, etc. (Spec	home, farm, stre	et, factory,	office		2	8f. Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Num	ber,
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my kr er: On the basis of examir and manner stated.	nowledge, death	occurred a estigation, i	t the time in my opir	, date and nion, death	place, a	nd due to the cau d at the time, dat	use(s) and ma te and place, a	nner as st	ated. the cause(s)
)	To th withir To th comp.	Me	29b. Signature and title of certifier	Tenu	MI) 29c.	License (number G [7/	29	d. Date signed	(Month,	Day, Year)	4
(No.	30. Name and address of person who com	npleted cause of death (Ite	em 23a) (Type, F	Print)	//	140	.50	1/10,	Ma	-×/	ant.	/
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	-/					2	2/2	US	, ,
1	Registra		IAN 2		for for	Anna Maria	1							

ORIGINAL

			For State Registrar	State o	f Marylar			of Healtle of Dea		lental Hy	giene Reg. No.	2004	01457
			Decedent's Name (First, Midd.	le, Last)						2. Date of De	ath		3. Time of Death
	Physicia		Beatrice Marie	Ness						Month Januar	Day 15.	Year 2004	10:25 p M
	/Medic Examin		4a. Fecility Name (If not institutio		mber)		4b. City, 7	Town, or Locati	ion of Death			County of Death	
	_Adimi.		Joseph Richey I	Hospice			Ba1	timore			N/	'A	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		1 Year If Un		8. Date of Bir (Month, De	th	9. Birth	place (State or Foreign
	Director		217-05-7252	1□M 2対F	91	Yrs.	WOILIS	Days 1100		4/9/19		i i	land
_	p ,		Usual Residence of Decedent 10a, State 10b, County		10c C	ty. Town or Lo	cation					1	10d, Inside City Limits
	aryla ehov	<u></u>	Toa, State Tob. County		100.0	ty, sown or Lo	Cation						1 ☐ Yes 2 ☒ No
	or 28a-f	cto	MD Balt:	imore	A1	butus	1017	0.4			10= Citiz	en of What Cou	
	with th	Director	10e. Street and Number				10f. Zip						
	e 23	by Funeral	5552 Oakland R		edent Ever in U	10 13	212		Origin? (Sp	ecify Yes or No		ted Sta	
	er de Item	Ē	11, Marital Status 1 ☐ Never Married 2 ☐ Mar	Amed Fo	rces?	7.3.	If Yes, spec	ify Cuban, Mex	ican, Puerto	Rican, etc.)		Black, White,	
36	irs aft	ķ	3 ☑ Widowed 4 ☐ Divorced	If Yas, Gir	ve		1 ☐ Yes 2	No Spec	cify:			Specify: V	Vhite
Ö	within 72 hours after death with the Maryland ene. then "natural", or teme 23e or 28e-f ehow ha Medical Examiner must be notified at	ed	15. Deceder	nt's Education		16a. Dece	dent's Usua	Occupation			16b. Kin	d of Business/în	dustry
7.	n n Neath	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of wor DO NOT us	k done during r e retired)	most of work	ang			
212	d with	E	8	00090 (Count	er Cl	.erk]	Food Sea	rvice
Þ	e filed wit al Hygiene I other the vent. In	Bec	17. Father's Name (First, Middle,	Last)				18. M	other's Nam	e (First, Middle	, Maiden S	Sumame)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mantal Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event. The Medical Examiner must be notified at	To E	John Bathgate					Aş	gnes H	lessian			
ary	should I and Meni market		19a. Informant's Name/Relations				•				,	Town, State, Zip	•
	1 and 2 Health a Iem 27 le		Geraldine Chil	dress-Tyna	an/daug	hter 5	5552 D	olores	-		ore, l	MD 21227	/
Je,			20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation	2 Demoval from	1	Place of Dispo cemetery, crea	nsition (Nam matory or ot	le of her place)		Date	20c. Loc	ation - City or To	own, State
LRE	Pages nent of ant: If It ary or o		'4 □Donation 5 □Other (S			yview (Cremat	ory	1/19/	2004	Balt:	imore, N	Maryland
4/ #	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licentes	(MA)			d Address of Fa	2 221			al Home	
5 m	89889		THE THE	XVX	XV	Lá	ansdow	me 2719	9 Hamm	onds Fe	erry I	Rd Lanso	lowne 21227
			23a. Part T. Enter the disease, o shock, or heart failure. Lis	r complications that	aused the dea	th. Do not ent	er the mode	of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Den	nentia							Onset and Death
	/Medical		resulting in death)	Due to	(or as a conse								700
7	Examiner		Sequentially list conditions	b									
10/5	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	quence of):							
S	cuter	Examiner	that initiated events) c									
	e exe ian a		resulting in death) Last	Due to	(or as a conse	quence of):							
11	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		d									
39	r certifica anding pl use as t	Med	IF FEMALE:									1	
Ϋ́	eath certif attending for use as	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregn pirth 2 □ Fet	al death 3	Ectopic pre				23	3d. Date of delive Month	ery Day Year
0.6	e deg	slc	1 ☐ Yes 2.5 No 9 ☐ Unknown	4∐Pregr 9☐ Unkn	nant at time of own	death 5	Other (spe	ecify)					•
<i>a</i> 6.	that the de ed by the detached	P _y	Part II. Other significant conditi	one contributing to d	eath but not re	suffing in the u	nderlying ca	use given in P	art I	23e Did t	nbacco us	e contribute to t	he cause of death?
15, Z	res tha signed I be de	by	Total		Rtoot	(1/10-		acc given in t	<u>.</u>	1 🗆		/	
o bio	w requir	eted	03,62	myches)	10,000	Die Car					-		
9) 9	law lasb	du								24a. Was	psy	prior to co death?	psy findings available mpletion of cause of
=		Completed								1 ☐ Yes	rmed? Z□No	1 Yes	2 No
ital	ting Physiclan: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medica examiner?						lace of Deat	th (Check only)	one)	,	17
がき	Physic this c	မှ	1 Yes 2 No		Inpatient 2	T			Nursing Ho	ome 5 Resi		Other (Special	MOSPIU
9 5	fing P	OU:	27. Manner of Death 1. ■Natural 5 □ Pendi		of Injury hth, Day Year)	28b. Time of Injury		Bc. Injury at Work?		28d. Describe	now injury	occurred	,
Si &	ttend death stor: /	cati	2 Accident invest 3 Suicide 6 Could	not be		1	М	1 Yes 2	2 🗆 NO	OR Leasting /	Ctrantand	Mumber of Com	I Courte Mirrobes
(X) ≅	for At after d Direct	Certification:	4 Homicide deterr	nined 286. Place build	of Injury - Ath ing, etc. <i>(Spec</i>	ify)	eet, factory,	, office		City or To	wn, State)	Number or Hurs	al Route Number,
/	u's a		20- 0-48 4F	- Cit in the Follow	s boost of a . I a	n I dec descri	1000 1100	Silk See deb			en autoba	-4	
M	To the Hospillet or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical		ng Physician: To the Examiner: On the b and man									
1	To the Hi within 24 To the Fi	Mec	29b. Signature and title of certific		stated.		29c.	License numb	oer		29d. Date	signed (Month,	Day, Year)
	To To Con	-	101. 10	1/-			7	5 1/25 1			2//	1/14	
	10		1 mey	1 (miles	ee of death (It-	m 23a) //	Print\	+7341			-//	10	
	8		30. N and address of pe so	wno completed cau	50 01 UBAIN (IIB	(Type,	(Tint)	2 (5		Balls.	-	10/11	187
	Sta	to	31. Date liled (Month, Day, Year) - 32. F	Registrar's Sign	ature	1000			pur VV	ing	100000	
	Registr			NA 2 9 200			4 1	a At					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Emma Marie O'Hearn JANUARY 19, 2004 /Medical 1230 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNIVERSITY SPECIALTY HOSPITAL N/ABALTIMORE CITY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ☐ F 25 220-90-0905 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. The file file 33 or 28s-1 show other traumatic event, the Healtest Examinar must be notified at Maryland N/A Baltimore 1 EYes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 S. Charles Street 21230 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Never Worked Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked ot Be Joyce Ann McCubbin David L. O'Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 601 S. Pulaski Street Baltimore, MD 21223 Joyce Ann Heinonen/mother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 1/22/04 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Pag Department Importent: I any injury o Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Cremation Society of Maryland, Inc. Dawn F <u>299 Frederick Road Baltimore, MD 21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Complications of Physician blunt resulting in death) /Medical Due lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? certificate 1X Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation Injury 1 Natural subject was beaton death. 1 Yes 2 No Found 7:20 AM 2 Accident I Diractor: d in by the 6-10-03 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1100 Whitmore Ave after 4 M Homicide To the Hospital o within 24 hours aft To the Funerel Di School yard Baltimore filled MO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mis w. OCME JANUARY 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

LING

31. Date filed (Month, Day, Year)

CI. MID

Registrar Signature

De Marie

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Raymond File Oler 10:30 pm 20, 2004 Jan. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Carroll Lutheran Village Westminster Carroll If Under 24 Hrs. 8. Date of Birth
Hours Min. June 18, 1905 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days 1 → M 2 □ F 98 Yrs. Director 216-05-7269 Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Manyland nent of Heelth and Mantle Ibygiene. Insit if item 27 is marked other than "natural", or items 23s or 28s-f show mit; if item 27 is marked other than "natural", or other traumatic event, fire Mangal Exeminer must be incitized at my or other traumatic event, fire Mangal Exeminer must be incitized at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director Carroll Finksburg 1 ☐ Yes 2 ☐ No Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21048 2802 Armacost Ave. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Plumber 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Colley Oler Elizabeth Arndt 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Oler - Son 2802 Armacost Ave., Finksburg, Md. 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremetion 3 ☐ Removal from State Druid Ridge Cemetery Jan. 24, 2004 Pikesville, Md. **Department** 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses 11605 Reisterstown Rd., Owings Mills, Md. 2111 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical nivestion Examiner Due to (or as a consequence of): Examine or Attending Physician: The lew requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24 hours after death.
 Funeral Director: After this certificate hes been signs letely filled in by the funeral director, page 2 should be v 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy 2 XNU 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Maturel 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office tuilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1737949 30. Name end eddress of person who completed causs of deeth (Item 23) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

32. Registra 6 Signatur

22 2004

Semen Au Westmite MO.

04-0302 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene 0 0 1 1 1/29/04 tas Registrar Amend Items 20a,b,c,per FH,G828,02/04/04/04/05 BASILE OTSIBA 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JAN. 12^{Pay} 2004^{Year} **Physician** 0258 /Medical 4c. County of Death 4b. City, Town, or Location of Death ta. Facility Name (If not institution, give street and number) Examiner BALTIMORE DUNDALK 2502 YORKWAY APT.B If Under 1 Year If Under 24 Hrs. 8. Date of Birth Worth, Day, 9. Birthplace (State or Foreign Sex M 2□F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Yrs. -099 Director Usual Residence of Deced the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or iteme 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Ever in U.S. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: 1 🗆 Yes 3 Widowed 4 Divorced "neturel", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natur any injury or other traumatic event, Ita Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant's Name/Relationship (Type, Print) 20c. Location - City or Town, State Franceville, Gabon Unk ethod of Disposition 3 Anemoyal from State **V**Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License av 40 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode shock, or heart failure. Lest only one cause on each line. Immediate Cause (Final disease or condition **Physician** MENINGITIS resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, francisco list in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year funeral director, page 2 should be detached for in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 DUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an 2 No Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 \(\text{Homicide} \) within 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the i 29d. Date signed (Month, Day, Year) JAN. 12, 2004 29c. License number 29b. Signature and title of certifier O.C.M.E

State Registrar

LING LI MiD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

mid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hi

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1300 EDWARD OLDS 2004 JAKE 13 JAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 0 212-69-7499 Yrs. Director December 26, 2003 Columbia, Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-1 show sust be notified at Columbia Director Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 U.S.A. 21045 5469 Treefrog Place or items 23a Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: Specify. 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) never worked al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) never worked permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygu Important: It item 27 is marked other any injury or other traum. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward Olds Kara Krier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Nama/Relationship (Type, Print) 5469 Treefrog Place Columbia, Maryland 21045 Mr. Edward Olds Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Jamestown, New York **Lakeview Cemetery** 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licensee Alch Mennelleelm Mass 35 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPOXIC - ISCHEMIC ENCEPHALOPATHY 18 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Criter Urbarying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown cate has been sig , page 2 should b 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Dthen: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 ZNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) io by 4 Homicide To the Hospitel within 24 hours a To tha Funeral C completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

GARY BLECHMUN

31. Date filed (Month, Day Yeg) 2 2004

ano,

57550 CEDAR LANE

32. Hegister's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

29c. License number

D39917

29d. Date signed (Month, Day, Year)

2064

	1	For State Registrar	State of Maryland	Certifi	cate of Dea	ath	riicai i iye	eg. No. 20	04 0146
		. Decedent's Name (First, Middle, Last)				2	. Date of Dea Month	th	3. Time of Death
hysician /Medical		Andrew Thoma	s Parincha	ak			_MONIN DAMUAR		1004 4.35 AN
Examiner	4	a. Facility Name (If not institution, give stre	the state of the s		City, Town, or Loca	tion of Death		4c. County o	f Death
		GOOD SAMARITA	+4 HOSPITA	+- 6	SALTIMO			N/A	
neral		Social Security Number 6. Sex	7. Age (In yrs. la	Mo	Jnder 1 Year If U	nder 24 Hrs. g	Date of Birth (Month, Day	Year)	Birthplace (State or Foreig Country)
ctor	_	109-20-3734	78	Yrs.			SEPT 1	2 <u>, 1925</u>	Pennsylvania
=	_	Jsual Residence of Decedent 10a. State 10b. County	10c. City	Town or Locatio	n				10d. Inside City Limit
7		Maryland N/A	Ral	timore					1 ∰Yes 2 □ N
ect	3	10e. Street and Number	Dai		of, Zîp Code			I0g. Citizen of W	hat Country?
event, the Medical Ever-time mast be rutified at Be Completed by Funeral Director	5			, ,	21239			USA	,
Funeral Director	5	6004 Wake Hurst Wa	.y . Was Decedent Ever in U.S	13 Was	ZIZJY Decedent of Hispani	ic Origin? (Speci			- American Indian,
, i	3	1 ☑ Never Married 2 ☐ Married	Armed Forces?	/.1	, specify Cuban, Me	xican, Puerto Ri	can, etc.)	Black	, White, etc.
by		3 Widowed 4 Divorced	1 Yes 2 No 19 If Yes, Give Year or Dates: 19	41-	es 2√No Spe	ecity:		Specify:	White
ed	<u> </u>	15. Decedent's Educat	tion	16a. Decedent's	Usual Occupation			16b. Kind of Bus	iness/Industry
Completed	1	(Specify only highest grade of	ompleted) College (1-4or 5+)	(Give kind life. DO N	of work done during DT use retired)	most of working			
E	5	Elementary/Secondary (0-12)	3	Radar				Westing	house
BeC		17. Father's Name (First, Middle, Last)			18. N	Mother's Name (First, Middle,	Maiden Sumame)
To B		George Parinchak			Г	heresa	Thomas		
other traumatic		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailing Ad	dress (Street and N			r, City or Town, S	itate, Zip Code)
1	1	Joseph Parinchak/B	rother	7810	Clark Road	l A1 J	essup,	MD 207	'94
	1	20a. Method of Disposition	20b. Pla	ace of Disposition	(Name of	Dat	0	20c. Location - C	City or Town, State
	1	1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren 1 ☐ Donation 2 ☐ Other (Specify)	noval from State	•	tory Inc.	1_221_	0/1	Balti	more, MD
	H	21. Signature of Fuger H Service Licenses		22 Na	me and Address of F	Facility			anore, rib
any injury or or.		Thomas Gregor	Try	Cre	mation Sc Frederic	clety o	i MD,	Inc. imore. M	ID 21228
	+	23a, Part1. Enter the disease, or complica	tions that caused the death.						Approximate Interval Between
		shock, or heart failure. List only one Immediate Cause (Final				_			Onset and Death
an :al		disease or condition resulting in death)	Due to (or as a consequ		A TORY	FAIL	ORE		
er					THORAY	ž.			
ĕ	5	Sequentially list conditions, b if any leading to immediate cause. Enter Underlying	Due to for as a consequ		(1,01-1,7				
Ë		cause. Enter Underlying Cause (Disease or injury that initiated events c							7
ai Examin	4	resulting in death) Last	Due to (or as a consequ	ence of):					
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Ž		IF FEMALE: 23c 23c	. If yes, outcome of pregnar	ncy				23d. Date	of delivery
Physician/Med	2	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3∐Ecto ath 5∏Oth	pic pregnancy er (specify)			Mont	h Day Year
ıysi	7	9 Unknown	9☐Unknown						
7	-	Part II. Other significant conditions contri	buting to death but not resu	lting in the under	ying cause given in I	Part I.	23e. Did to	bacco use contril	oute to the cause of death?
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Completed	2	ACUTE REMA	AL FAIL	185			24a. Was a	n 24b. W	ere autopsy findings availab ior to completion of cause of
Comp	-						autops perfor	med? de	ath?
			RILLATION	7					☐Yes 2区No
Be	۵.	25. Was case referred to medical examiner?	spital:		Othor	Place of Death (
To B	-16	T THE ZX NO	impatient 2018	P/Outpatient 3 28b. Time of	1 DOX 41			ence 6 Other	
o u	5	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 □ Yes				
	ğ	2 Accident investigation	20 Place of Injury . At hor				f Location /S	treet and Number	r or Rural Route Number,
icat	=	4 Homicide determined	 Place of Injury - At hor building, etc. (Specify))	actory, office		City or Tow	n, State)	
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Ø 0	200	co. C. diller Cardifiling Churcia	r: On the basis of examinati	ion and/or investi	gation, in my opinion	, death occurred	at the time, d	ate and place, ar	nd due to the cause(s)
ical Certificat	במו כפנ	29a. Certifier (Check only 2 Medical Examine)							
Aedicai Certificat	ecical	(Check only 2 Medical Examine one)	and manner stated.		29c License num	ber	1 2	Denniz etaci nP	(Month Day Year)
Medical Certificat	ecical	(Check only one) 2 Medical Examine 29b. Signature and title of certifier	and manner stated.		29c. License num			me.	(Month, Day, Year)
Medical Certificat	Medical	(Check only 2 Medical Examine) 29b. Signature and title of certifier	MD		RES C	000	7	AHUA RY	
Medical Certificati	Medical	(Check only one) 2 Medical Examine 29b. Signature and title of certifier	pleted cause of death (Item	23a) (Type, Print	RES C	MYOM	ATOR	AHUARY	20,2004
completely filled in by the funer Medical Certification	Medical	(Check only 2 Medical Examine) 29b. Signature and title of certifier	pleted cause of death (Item	,5601 L	RES C	MYOM	ATOR	AHUARY	

DHMH 17 Rev 1/2001

ANDREW PARINGHAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 9100 PM Bobinson 2004 eonard 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SQUARE Rosedale
If Under 1 Year | If Under 24 Hrs. HOSDILA IIMORE 7. Age (In yrs. last birthday). Birthplace (State or Foreign Country) 60Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Months Hours Min. 1 M 2□ F 219-32-9656 MD Usual Residence of Decedent 10a. State 10b. County NA 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 42U Baltimore <u> १८६१६</u> 2749 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ia bov 19 Canning 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eleanor Bernard Robinson Kru 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St Battimere MD alaa4
20c. Location - City or Town, State Bobinson WiFe 2742 E. Baltimore Constance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1-28-04 Balto, MD * 4 ☐ Donation 5 ☐ Other (Specify) Metrol 22. Name and Address of Facility Funeral Service Li 21. Signature IAM 1932 Mid Vellay Dr. Jessuz, PA 18434 Approximate Interval Between Onset and Death Part 1. F of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Hemorrh gic Infarct fleft hemis phere with Immediate Lause (Final disease Condition resulting in death) 2 hours Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interest. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify)

Priysician /Medical

Physician

Examiner

Director

Completed

Funeral

Director

Baltimore, Maryland 21215-0036

CONAR

d 2 should be fi th and Mental H 7 Is marked of

Pages 1 and 2 ment of Health a ent: If item 27 Is

permit. Page Department of Importent: If eny injury or once.

/Medical

Examiner certificate be executed attending physician and for use as the burial-transit The law requires that the death

certificate has page 2

To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fune.

Division of Vital or Attending Physician: Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

29a. Certifier

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗀 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an 1X Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Yes 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No

2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Dr. Krysten Fairbanks

29c. License number

00057573

29d. Date signed (Month, Day, Year)

Kyster D. de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Fran

State Registrar 31. Date filed (Month, Day, Year) 32. Registar's Signature 2004

	•	For State Registrar	State o	f Marylan	d / Depa <i>Cer</i>	artmen tificate	t of H e of L	ealth a D <i>eath</i>	and M		giene (2004	01464
Physicia	n	Decedent's Name (First, Middle, Oscar Rene	Last)							2. Date of Dea Month Januar		,2004	3. Time of Death 8:55 P M
. /Medica Examine		4a. Facility Name (If not institution, Holy Cross Host		mber)				Location of			4c. C	ntgome	h
Funeral Director		5. Social Security Number 133–46–9548	5. Sex 112∏ M 2□ F	7. Age (In yrs. 66		If Under Months		If Under: Hours	_	8. Date of Birth (Month, Day May 5,	(Year)	9. Bin Co Tri	hplace (State or Foreign nitry) nidad & Taba
se Maryland 8e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Montgor	nery		, Town or Lo	wn							10d. Inside City Limits 1 ☐∰yes 2 ☐ No
th with th	al Dire	10e. Street and Number 6 Birdseye Cou	ırt			10f. Zip	60de 1874				10g. Citize	on of What Co	USA
J36 irs after dea il, or Items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed Fo	2 📉 No	i i	Was Deced fYes, spec 1 ☐ Yes 2			gin? (Spe , P <i>u</i> erto	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit pecify:	
ING Z1Z13-UU35 be filed within 72 hours after death with the Maryland ital Hygiene. id other then "netural", or items 23a or 28e-f show event, Its Medical Examination in the modified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1.2	Education			lent's Usua kind of wor DO NOT us	k done d e retired,	luring most)	of worki	ng		of Business/	Industry
E B E B	To Be Co	17. Father's Name (First, Middle, L Henry Rene	ast)		7140		, ridir	18. Mothe		(First, Middle, Armour	Maiden S	umame)	
ore, Marylan stand 2 should be stand 2 should be of Health and Mental item 27 is marked to other treumatic eve		19a. Informant's Name/Relationshi Elva Rene - Si				-				<i>l Route Number</i>			Zip Code)
IMORE, IN Pages 1 and 2 nent of Health int: If item 27 ury or other tr	9	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of the Control o		State Riv	lace of Dispo emetery, cren erdale	sition (Nam natory or ot Park	ne of therplace Cre	em. 1				ation - City or cdale,	
baltimo		21. Signature of Funeral Service Li	Vielean	0 76	√ 38	331 Ge	org	ia Av	e.,N	tney's : W, Wash	ingto		
Pilysician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. $\frac{\mathrm{Def}}{\mathrm{Due}}$ to	nach line. Nydratic (or as a consequ	on vence of):		e of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
8 / bU, cate be executed bysician and the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate care. The U.J. The Cause (Disease or injury that initiated events resulting in death) Last	c. Ser	ite Rena (or as a consequ Osis (or as a consequ Dernatre	vence of):	lure							
the death certification by the attending properties tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregna irth 2 Tetal ant at time of de own	death 3	Ectopic pro					23	d. Date of deli Month	very Day Year
es the	ρ	Part II. Other significant condition	s contributing to d	eath but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to			the cause of death?
The ate ha	Completed									24a. Was a autops perform	sy med?	prior to death?	topsy findings available completion of cause of 2 No
this lab	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Xt Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Otter 27. Manner of Death 5 Pending investigation 1 Xt Accident 5 Pending investigation 1 Accident 1											cify)
is it is	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 288. Flace	of Injury - At ho ng, etc. (Specify	me, farm, stre	et, factory	, office		2	28f. Location (St City or Town		Number or Ru	ral Route Number,
he Hospi n 24 hou he Funer pletely fill	Medical	(Check only 2 Medical E	Physician: To the xaminer: On the band man	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	estigation,	in my op	inion, deat	d place, a	ed at the time, d	ate and p	lace, and due	to the cause(s)
0 0 mit 7	~	29b. Signature and title of certifier	2 101	Own	lag	~_	D00	05896	55	2		ary 15	
		30. Name and address of person w Saima Khawaja	, MD 1	1119 Roc	kville	•	e #1	00, R	ockv	ille, M	D 208	352	
Stat Registra		31. Date filed (Month, Day, Year)	2 2 2004)	egistrar Signal	LUTE A.	Long	alle)	i					

				1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment tificate	of Health a	and Me		iene2 0 0 4	01465
				Decedent's Name (First, Middle, Last)					- 2	2. Date of Deat	n .	3. Time of Death
		Physica /Medi		Sandra Jean Rile	У		11 O'S T	- lastin		Month January		10:45 AM
•	7	Examir	ner	4a. Fecility Name (If not institution, give s				own, or Location of			4c. County of Dea	
				3807 Annapolis R			Balt If Under 1	rimore H	ighla:	nds B. Date of Birth		timore
		Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) 51 Yrs.		Days Hours	Min	(Month, Day,	Year) 9. Bir	thptace (State or Foreign buntry)
		Director	ļ	232-02-5273 Usual Residence of Decedent		51 Yrs.				Jec. 31	, 1952 Wes	t Virginia_
		and w		10a. State 10b. County	100	City, Town or Lo	cation					10d. Inside City Limits
		Aaryl sho	ŏ	MD Baltim		n - 1 +	d	III ah 1 am	J _			1 ☐ Yes 2 No
		28a-	Director	MD Baltim 10e. Street and Number	ore	Dalt	10f. Zip C	Highland	us	10	og. Citizen of What Co	ountry?
		with	0					21227			United Sta	
		death with the Maryland ms 23s or 28a-f show fmust be notified at	era	3807 Annapolis R	12. Was Decedent Ever	in U.S. 13. \	Vas Deceder		ain? (Speci		14. Race - Ame	
		ter d	Funeral	1 Never Married 2XXMarried	Armed Forces?	1		nt of Hispanic Ori y Cuban, Mexicar		can, etc.)	Black, Whit	
	38	urs al	þ	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		∣∏ Yes 2∛	No Specify:			Specify: W	hite
	Maryland 21215-0036	2 ho	Completed	15. Decedent's Edu	cation	16a. Deced	ient's Usual (Occupation	t of working	1	6b. Kind of Business	Industry
	218	hin 7	ple	(Specify only highest grade	College (1-4or 5+)	life. L	DO NOT use	done during mos retired)	t of working	′		
	2	gien gien er th	6	11			Homen				Own Home	
	9	al Hy al Hy I oth	Be (17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First, Middle, N	faiden Sumame)	
	<u>a</u>	Went Went wrkee	2	Edward Mundy Kis	ner			Emr	na Jea	an Prit	t	
	lan	2 sho and I s mu		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (S	Street and Number	er or Rural I	Route Number,	City or Town, State,	Zip Code)
5	Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: if item 27 is marked other than "natural", or itams 23e or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.		Tammy J. Himes							, MD 21223	
4	Baltimore,	of Her fitter roth		20a. Method of Disposition 1□Burial 2\(\overline{\text{D}}\) Cremation 3 □R	emoval from State	Ob. Place of Dispo cemetery, cren	sition (Name natory or othe	er place)	Da	le 2	toc. Location - City or	Town, State
10	Ĕ	Pagnent ant: I		4 Donation 5 Other (Specify)		ayview C	remato	ry, Inc.	. 1-23	3-2004	Baltimore	, MD
5	alt	portribut.		21. Signatule of Funeral Service Licens	STI. (7	1 x = 0 1 22	. Name and	Address of Panel	rose	Funera:	l Home of	Lansdowne
540	8	89 2 2 9		Calletio NI	Cherry M	433/27	19 Ham	monds Fe	erry E	Rd., Lai	nsdowne, M	D 21227
~	P			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	death. Do not ente	er the mode	of dying, such as	cardiac or	respiratory arre	st,	Approximate Intervat Between
		Physician		Immediate Cause (Final disease or condition	Chronic obs	tructive	pul	monary	die	CASP		Onset and Death Vears
	16	/Medical		resulting in death)	Due to (or as a cor	rsequence of):	T W	- Comment	0000			yours
		Examiner		Sequentially list conditions								
40/61		D =	Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):						
10		acute ind trans	am	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
2	0,	e exe sien a urial-		resulting in death) Last	Due to (or as a cor	nsequence or):						
-	68760,	certificate be executed iding physicien and ise as the burial-transit	Physician/Medical		1							
	9	ing p	Mec	IF FEMALE:				. ,				
+	Box	ath co	an/	23b. Was decedent pregnant in the past 12 modifies?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic preg				23d. Date of del	ivery Day Year
0	0	the a	SIC	1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown	of death 5	Other (spec	orfy)				
_	Ρ.	es that the death certificate be executed igned by the attending physicien and be delached for use as the burat-transit		Part II. Other significant conditions con	stributing to death but no	t resulting in the ur	derking cau	ise awan in Part I		23e Did tob	acco use contribute to	the cause of death?
Q	S	signed det	b	Diabetes	minutes to double but no	trosoning in the di	iddilywig dad	iso givon in r anti-			s 2□No 3 Pr	
4	0	per meen	etec	Diabolic								
andy	ec	> 11 (2)	Completed							24a. Was an autopsy	prior to	topsy findings available completion of cause of
2	E H	The cate has	Co							perform 1 Yes 2		2 No
8	/ita	cian. ertifi	Be	25. Was case referred to medical examiner?	loopitals				of Death (Check only one)	
()	of Vital Records,	Physician: r this certific ral director,	2	TU TOS ZUENO	· · · · · · · · · · · · · · · · · · ·	2 ER/Outpatien					nce 6 Other (Spe	cify)
	n c	After uner	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury		Work?		d. Describe nov	w injury occurred	
	Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injury	At home form ste	M	1 Yes 2 1		f Location /Str	eet and Number or Ru	um I Pauto Mumbos
	Σ	or Al	ırtif	4 Homicide determined	28e. Place of Injury - building, etc. (Sp	pecify)	et, ractory, c	OTICE	20	City or Town,		rai Houte Number,
		Hospital 24 hours a Funeral D		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge death		1h. 1 data	d =1=== ===			
	1	To the Hospital or Attending Physician: The fav within 24 hours after death. To the Funeral Director: After this certificate has completely liked in by the funeral director, page 2	edical	(Check only one)	nar: On the basis of examination manner stated.	mination and/or inv	estigation, in	n my opinion, dea	th occurred	at the time, da	te and place, and due	to the cause(s)
_		To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. l	License number		29	d. Date signed (Monte	h, Day, Year)
		- > - 5		STEDIA			7	24170	,	1	D-lanuar.	2004
	1	7		30. Name and address of person who co	moleted cause of death	(Item 23a) (Type		11/0			~ January	
		V		E. Tso MD Riche	v Hospice	838 N	Entan	St B	altimo	re M	OJanuary D 21201	
		Sta		31. Date filed (Month, Day, Your)	2 2038 Registraft S	Signature	Ana	Als >				
		Registr	2.	CHARLE OF	IN MUUTE PART	Service All	N. S. A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Oate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:00 A M Riborg Steger Η. 21 2004 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2908 White Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 25xF 90 265-82-9778 Director APR 17, 1913 Norway Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 is marked other then "natural", or items 23a or 28e-1 ehow traumatic event, the Madical Examiner must be notified at 1 Yes 2 No by Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2908 White Avenue 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iter eny injury or other traumatic event; the Medical Examina-1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ◯ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thorolf Ellingsen Signe Julene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karin Ashe/Daughter 1914 Parsonage Road Parkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, MD 1-21-04 21. Signature of Funeral Service License 9

Thomas Gregor 22. Name and Address of Facility Cremation Society of 299 Frederick Road 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SC U Immediate Cause (Final 142 **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ierel Director: After this certificate has filled in by the funeral director, page 2 1 Yes 25XN0 To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident A Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19503 January 21, 2004 of death (Item 23a) (Type, Print) GERARO AUCA14 TIMONIUM MO 21093. 32. Registrar's signature State Registrar

			State of Maryland / Department of Health and Maryland / Department of Health And Maryland / Department of Health And Maryland / Department		ene 2004	01467
	Physici	an	1. Decedent's Name (First, Middle, Last) Merry Patricia Siemen	2. Date of Death Month	Day Year	3. Time of Death 5:12 AM
•	/Medic Examir	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dear	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A 9. Bin	hplace (State or Foreign
٦	Director		212-34-9907 1□ M 2♥ F 68 Yrs. Months Days Hours Min.	DEC 25,		yland
Siemer	nyland show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ick	with the Maryland a or 28a-f show Lee ricelling at	recto	Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	1 ☐ Yes 2 ☐ No untry?
-	₽ 83 ₽	Funeral Director	14611 Philip Court #3 20708		ISA	
Merry	8 E 5	/ Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 ☐ Yes 2 ☐ No 11 ☐ Yes 3 ☐ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
3		ted by	3 Noticed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	. 16	6b. Kind of Business	
	32	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Home	
	filed Hygi other	Be Co	14	ne (First, Middle, Ma		
Known	Maryland d 2 should be file th and Mental Hy t7 Is marked oth traumatic event	10	Wilbur Plitt Sophia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		City or Town, State, 2	Tip Code)
	mand 2 seatth and 2 seatth and 27 ls		Martin Siemen/Son 14611 Philip Court #3	Laurel	, MD 207	08
nt	Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any jointy or other traumatic ex		20a. Method of Disposition 1 Burial 2 Commation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 1-2		oc. Location - City or Baltimor	
Patrent	Battir permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society			c, 110
Va	u aceaa	10. 1	Thomas Gregor / 299 Frederick Road 23a. Parli. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Baltim	ore, MD	21228 Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Ceva by vascular Accident			Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			lday
	Sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	K / 5U, ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
	icate be ex physician a sthe burial	dical	d			
	BOX 6 eath certitic attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of del	very Day Year
(at the death	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		World	Day Foai
	S, F	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobar	cco use contribute to	the cause of death?
	as been signal to the state of	piete		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	VICAI MEC ician: The lav certiticate has rector, page 2			performe 1 ☐ Yes 2 ☑	d? death?	2 1 NO
	OT VIT Physicial this certif	To Be	examiner?	th <i>(Check only one)</i> ome 5 Residence	ce 6 □Other (Spec	afy)
	ION O	ation;	27. Manny of Death 1 Chatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 Pending (Month, Day Year) 1 Pes 2 No	28d. Describe how	injury occurred	
	DIVISIO I or Attendi after death. Director: A	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
11	a ∃ a ≡	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the caus red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the Hosi within 24 ho To the Fun completely t	Med	29b. Signatur and title of certifier 29c. License number	29d	. Date signed (Month	n, Day, Year)
	1		30. Name and India's of person who completed cause of death (Item 23a) (Type, Print)	D	1 18 04	
	2		Joy El Ballard, M.D. Simi Hospital of Bul	house		
	Sta Registi		31. Date filed (Month, Day, Year) AN 2 2 3 1 1 1 2 3 1 1 1 1 1 1 1 1 1 1 1 1			

			For State Registrar	State of M	aryland /		ertment o			nd M	-	giene ,	2004	01468		
			Decedent's Neme (First, Middle, Last)							2. Date of Death 3. Time of Death				3. Time of Death		
	Physici /Medio		Arla Mary Starks					Januar					2004 er	05:45 P M		
	Examir		4e. Fecility Name (If not institution, give street and number) 4b. City, Tow						ocation o	f Death		4c. County of De				
			Genesis Eldercare Severna Park					Severna Park					ne Arun	del		
	Funeral Director						If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Aug 2					Birth 9. Birt 9. Birt 9. 1915		place (State or Foreign ntry) Kentucky		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show eny injury or other traumatic event, the Medical Examiner must be notified at 90cs.		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tox	m or La	antina									
		ъ	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No													
		ect	10e. Street and Number 10f. Zip Code									40 011	n of What Cou			
		ក់	8411 Bussenius Road					21122					J.S.A.	ntry r		
		era											. Race - Ameri	can Indian		
920		by Funeral Director	1 Never Married 2 Married 1 Yes 2 No				Nas Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes						Black, White, etc. Specify: White			
Ò		ted						ent's Usual Occupation 16 kind of work done during most of working					of Business/In	dustry		
Maryland 21215-0036		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Give kind of work done during m life. DO NOT use retired) Homemaker						ring most				Own Home			
		To Be C							, , , , , , , , , , , , , , , , , , , ,	rst, Middle, Maiden Sumame) Wallace						
ary.		-	19a. Informant's Name/Relationship (Type	oe, Print)	19	b. Mailin	g Address (Str	reet an	d Number	or Aura	I Route Numbe	r, City or T	own, State, Zig	Code)		
ž			Mr. Darrell Lee S	Starks /							sadena,		21122	•		
Je,			20a. Method of Disposition				sition (Name or		ί,		ate	20c. Loca	tion - City or To	own, Stete		
E			1 🌣 Burial 2 □ Cremation 3 □ Removal from State Ceda (************************************						"Vemetery Jan 19 2004 -				Baltimore, MD			
Baltimore,			21. Signature of Funeral Service License	99		1	Name and Ad	ddress A v	of Facility enue	Sin SW	gleton Glen B	Funer	ral Hom	e, P.A. 21061		
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate													
	cian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
			Sequentially list conditions,			1.00										
		ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):												
		Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):												
8760,		dicai E														
9		edic														
.O. Box		/ Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Klo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown									23d. Date of delivery Month Day Year				
<u>α</u>			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?					
Records,		sted by	Congestice Heart Farher									1 Yes 2 No 3 Probably 4 Wunk				
_		Completed	17	ypeille	nwy						24a. Was a autop: perform	sv	24b. Were auto prior to cor death? 1 Yes	psy findings available inpletion of cause of		
Vital		Be	25. Was case referred to medical examiner?	ospital:				2	6. Place	of Death	(Check only or	18)				
)		ဥ	1 195 212140	3L DOA	, , , , , , , , , , , , , , , , , , ,						()					
n C		lon	27. Manner of Death 1 SNaturel 5 ☐ Pending	(Month, Day Year) Injury Work?						8d. Describe how infury occurred						
isic		icat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of Init	M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number,								
Division of		Certification:	4 Homicide determined	d building, etc. (Specify)						City or Town, State)						
		ledical	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
)	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1504													
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRIDITIBLE ATWR, 8109 Fitchie Hway, Panadona, MD 21122													
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrate Signature JAN 2 2 2004													
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 1 0 | 469 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17 2004 08:34 PM January Smith Orville Gary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel 1102 Marley Creek Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1**X** M 2□ F 212-44-9479 58 Yrs 13 Mary land July Director Usual Residence of Decedent 10d. Inside City Limits with the Manyland 10c. City. Town or Location 10b. County 10a. State show r than "naturel", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 X No Glen Burnie MD Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21060 1102 Marley Creek Drive Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after to the Hygiene.

Other than "naturel, or iter 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2X No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Longshoreman Cargo / Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 is marked oth any light yor other treumatic event sone. Unknown Orville Wright Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6030 Burnt Oak Road Catonsville, MD Dean Smith / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan 1 Burial 2 □ Cremation 3 □ Removal from State 2004 Glen Haven Memorial Park Glen Burnie, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Sign were of Fyncal Service Licensee molly Glen Burnie, MD 21061 1 Second Avenue SW 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impediate Cause (Final disease or condition resulting in death) Arterioseleratic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Id be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? (es 2 No 1 ☐ Yes 2 ☐ No 1 Yes this certificate To the Hospitel or Attending Physician: 26. Place of Death Check only one Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending investigation 1 ■ Natural 2 □ Accident 1 Yes 2 No death. the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cay of death (Item 23a) (Type, Print) merica Illiam ONES 31. Date filed (Month, Day, Year) JAN 2 2 2004 | JAN 2 2 2004 State Registrar ORIGINAL

	ian	1. Decedent's Name (First, Midd	Jul CE	SIEWA	KT- HUS	PSOA)	2. Date of Death Month	Day Year	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution	on, give street and number		4b. City, Town, or I			4c. County of Dea	
			eorges	HOSLILAY	- CHEV			PRINCE	GEORG
Funeral Director		5. Social Security Number 354–38–1674 Usual Residence of Decedent	6. Sex 1 □ M 2 □ X 5	Age (In yrs. last birthday 57 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 17,	9. Bir 1946 Ch	thplace (State or Fore ountry) Licago, IL
natural', or Itama 23a or 28a-1 show Jical Exertinal must be inclifted at	_	10a. State 10b. Count	у	10c. City, Town or L	ocation				10d. Inside City Lin
28a-f	Director	IL Cook		Chicago					MXYes 2□
3a or	I Dir	10e. Street and Number 11521 s. Lowe	2		10f. Zip Code 6062	20	10g.	Citizen of What Co	
ema 2 ar mus	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.	. Was Decedent of His If Yes, specify Cuban		cify Yes or No-	US 14. Race - Ame	erican Indian,
"natural", or Itema 23a or 28a-f show adical Exactinat must be notified at	þ	1 Never Married 2 Mai 3 Widowed 4 Miorce	rned 1 Tyes 2	Mo	_	Specify:	Hican, etc.)	Specify: B	le, etc. Lack
- 66	ojete	(Specify only highe	nt's Education est grade completed)	16a. Dece (Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	ion Iring most of working	ng 16b	. Kind of Business	/Industry
Hygiene. ther than nt, the Max	Completed	Elementary/Secondary (0-12)	College (1-4o	(3+)	Lice Office			County Go	Vernment
la do	To Be C	17. Father's Name (First, Middle, Charles Stewa		•			(First, Middle, Maid		vermment
f Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relations	ship <i>(Type, Print)</i> on – Daughte	19b. Mail r 3645	ing Address (Street and Elder Oak	nd Number or Rura SS, Blvd	Route Number, Cit #7102, M	ty or Town, State, I BOWIE 1 tchcllv	Zip Code)
or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State		matory or other place)) !		. Location - City or	Town, State
ant ury		* 4 □ Donation 5 □ Other (5	11	y 1/24/		Illinois			
Depart Import		21. Signature of Furieral Service		7)	2. Name and Address 331 Georgia	ца	tney's Fu	neral Ho	me
The law requires that the death certificate be executed ale has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a b. Due to (or a c.	s a consequence of): s a consequence of): s a consequence of):	LUA	JG CA	ncer		Onset and Death
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ate has page 2	e Completed	25. Was case referred to medica					24a. Was an autopsy performed?	prior to c death?	topsy findings availa ompletion of cause (2 \sum No
nis certific I director,	To B	examiner? 1 ☐ Yes 2 ██	Hospital:	ent 2 ER/Outpatier	Dthor	6. Place of Death	Check only one) 9 5 Residence	6 ∏Other /Snec	efv)
death. ctor: After this / the funeral dir		27. Manner of Death 1 Setural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation	ury 28b. Time of Injury	Work?		d. Describe how in		,,
fter Direction	O	4 Homicide determ	ined 286. Place of In	jury - At home, farm, str tc. (Specify)			f. Location (Street a City or Town, Sta	te)	
8 4 7	edical	29a. Certifier 1 Medical (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis of and manner st	a examination and/or in	n occurred at the time, vestigation, in my opini	date and place, an ion, death occurred	d due to the cause(at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
n 24 he Fu					29c. License ni		00.1.0		
within 24 hours a To the Funeral (completely filled	Σ	29b. Signature and title of certifie	/			51483		ate signed (Month	, Day, Year)

			1 - For State Registrar		nd / Departm	ent of Health and ate of Death		ne 2004	0147
•	/N	/sician ledical aminer	1. Decedent's Name (First, Middle, Las MINNIE 4a. Fecility Name (If not institution, give Mercy Ridge	street and number)	T	ity, Town, or Location of Dea	January	Day Year 20 2004 4c. County of Death Baltm	3. Time of Death 9, SO M
	Fund Direct		5. Social Security Number 6. Security Number 217–38–1954	90 90 P 2	Mont	der 1 Year If Under 24 Hrs hs Days Hours Min	8. Date of Birth (Month, Day, Ye December 1	9. Birthp Cour. 5,1913 Ma	10 10 1 1 To 10 10 10 10 10 10 10 10 10 10 10 10 10
	e Maryland	ctor	10a. State 10b. County		ty, Town or Location			1	10d. Inside City Limits 1 ☐ Yes 2 No
	h with th	al Director	10e. Street and Number 2525 Pot Spring Rd	.•		Zip Code 1093		Citizen of What Cour	
	and 21215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. ed other than "natural", or flems 23a or 28e-f show	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 \(\subseteq Yes \) 2 \(\bar{Y} \) No If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic Origin? (specify Cuban, Mexican, Puers 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	can Indian, etc.
	1215-0 /ithin:72 ho ne. hen "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	sual Occupation work done during most of wo Tuse retired)	orking 16b	. Kind of Business/Inc	·
D. W.	be filed tal Hygi	To Be Col	17. Father's Name (First, Middle, Last)	2	nur	18. Mother's Na	me (First, Middle, Maid 1 Fenhagen		<u>.1</u>
			19a. Informant's Name/Relationship (7 Michael X. Smith/s			ess (Street and Number or A Farm Rd. E	ural Route Number, Cit Baldwin, MD		Code)
	Baltimore, Normal, Pages 1 and Department of Health mportant: If Item 27	y or our	20a. Method of Disposition 1	Removal from State	Place of Disposition (I		Date 20c.	Location - City or To	
,	Baltimor permit. Pages Department of H Important: If Ite	once.	21. Signature of Funeral Service Licens	Tull I	22. Name	and Address of Facility itchell-Wiede 500 York Rd.	feld Funera		
•	balvacien be executed Examin Examin Physicien and Shakering Physician and Shak	cal Examiner	23a. P&f1: Enter the disease, or composition of the	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	node of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death MONTHS
, 2004	Hecords, P.O. Box 68 The law requires that the death certifica lie has been signed by the attending ph	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 Ectopic			23d. Date of deliver Month	ny Day Year
N	rds, r quires that n signed b	d by Pt	Part II. Other significant conditions co	entributing to death but not res	ulting in the underlyin	g cause given in Part I.		o use contribute to the	
	- 0 '	omp					24a. Was an autopsy performed?	prior to corr death?	osy findings available inpletion of cause of
TH	OT VITAL Physicien: 7 This certificet	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other	ath (Check only one) Home 5 Residence	6 ⊠Other (Specify	ASSISTED
	Attending Part death.	ation:	27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
MINNIE	Direction 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, fact y)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural lite)	Route Number,
7 M	the Hospital thin 24 hours a the Funeral E	Medicai (29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exemi	sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause irred at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
Ò	To the Within To the	Σ	29b. Signature and title of certifier	Worcht	WD	DS274	7	Date signed (Month, D	lay, Year)
	3	1	30. Name and address of person who con ERNESTINE A. WRIC			VALLEY POAD	TIMONIUM	MD 21093	
	Rec	State istrar	31. Date filed (Month, Day Yes) 2	2 2004 Registrar's Signa		who home	22110147014	110 21093	

Fr 04	ederick -0409	L	. Sonnemann Please Ty							le.
AK	G		1 - State Allended Item#2 Registrar Unpended Item#2		yland / Depa 27, Per ME, G	tificate of t			Reg. No.	04 01472
	Physici	an	Decedent's Name (First, Middle, Last)			-		2. Date of De	Day	3. Time of Death
	/Medic		Frederick Lamo 4a. Fecility Name (If not institution, give str		emann, III		or Location of Death	Janua:	4c. County o	
	Examin	ier	8137 Harold Court	Apt. 2A		Glen Bu	mie		Anne A	Rundel
ī	Funeral		Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	(Month, Di	rth ay, Year)	Birthplece (State or Foreign Country)
465	Director		578-30-0406 Usual Residence of Decedent	7 20 5	77 Yrs.			Feb. 1	6, 1926 V	Washington, DC
	land wo		10a. State 10b. County	1	Oc. City, Town or Loc	cation				10d. Inside City Limits
	Many	tor	Maryland Anne Arun	de1	(denton				1 ☐ Yes 2 🕅 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	ath w	ral	501 Rita Drive			211		2 32 31	United S	
	items items nert.	Funeral	11. Marital Status 12 1 ☐ Never Married 2 ▼ Married	. Was Decedent Ev Armed Forces?	lf If	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)		- American Indian, , White, etc.
215-0036	72 hours after death with the Maryland natural', or items 23e or 28e-f ehow disal Examinational be notified at	by	3 Widowed 4 Divorced	1X Yes 2 □ No If Yes, Give Year or Dates:	1	☐ Yes 2¶ No	Specify:		Specify:	White
2-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of		(Give I	ent's Usual Occup	during most of wor	kina	16b. Kind of Bus	iness/industry
121	within ene. then	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	nd)		United S	
d 21	Hygie Hygie other t	CO	12th 17. Father's Name (First, Middle, Last)		Pos	stal Car		ne (First, Middle	Postal S	
Maryland	d la b	To Be	Frederick Lamon	te Sonn	emann, Jr		Miriam	Alvir	ta Morto	on
ary	should and Men emarke	-	19a. Informant's Name/Relationship (Type			Address (Street	and Number or Ru	ıral Route Numb	er, City or Town, S	tate, Zip Code)
	1 and 2 Health a Iom 27 io		Miriam Alverta Sonn	emann/Dau	A STATE OF THE STA	l Rita D	rive Od	CONTRACTOR OF THE PARTY	Maryland	
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 Burial 2DCremation 3 Per	noval from State	-	atory or other pla	.	Date	20c. Location - C	ity or Town, State
ij	permit. Pag Department Important: I eny injury c		* 4 □ Donation 5 □ Other (Specify)		West Arund			7/2004	Odentor	n, Maryland
Bal	permit. Page Department Important: Il eny injury o		21. Signature of Funeral Service Licensee		I	Name and Addre Oonaldso:	n Funeral apolis Ro	Home &	Cremator	ry, P.A. aryland 21113
	18.		23a. Party. Enter the disease, or complica	ations that caused th	e death. Do not ente					Approximate Interval Between
ı	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition		ral Henorrha	æ				Onset and Death
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	ped usit	nlner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of :					
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	death certificate be e attending physicia ed for use as the bui	Physician/Medical	IF FEMALE:							
Вох	ath ce ttendii or use	an/	23b. Was decedent pregnant in the past 12 months?	i. If yes, outcome of 1 Live birth 2	☐ Fetel death 3 ☐	Ectopic pregnanc	у		23d. Date Monti	
	0 6 5	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death 5	Other (specify) _				
P.0	law requires that the dias been signed by the 2 should be detached		Part II. Other significant conditions contri	ibuting to death but	not resulting in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
Records,	requires been sign should be	d by	Hypertensive Atheroscle	rotic Cardio	ovascular Dis	sease		1 🗆	Yes 2□No 3	☐ Probably 4 风Unknown
000	aw requ is been 2 shouk	Completed						24a. Was	an 24b. We	ere autopsy findings available or to completion of cause of
	9 4 9	oml							ormed? de:	ath? Yes 2□ No
Vital	ysician: Th	Bec	25. Was case referred to medical examiner?				26. Place of Dea		one)	
of V	Z	မ	1⊠Yes 2□No		2 ER/Outpatient	3 DOA				(Specify) At scene
	ding After	tlon	27. Manner of Death 122Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	/ear) 28b. Time of Injury	28c. inju Wo M 1	rk?]Yes 2□No	280. Describe	how injury occurred	
Division	Attending ir death, actor: After by the fune	ficat	3 Suicide 6 Could not be		- At home, farm, stre		, , , , , , , , , , , , , , , , , , , ,			or Rural Route Number,
Ö	al or safter	Certification:	4 Homicide	building, etc.	(Specify)			City or To	wn, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Diractor: completely filled in by the	edical (29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine							
	the hin 24 the F	Medi	one)	and manner state	d.	29c. Licens			29d. Date signed (
	Wit To		29b. Signature and title of certifier	からう		O.C.M			January :	
		1	30. Name and address of person who com	pleted cause of dea	th (Item 23a) (Type F				Januar ₁	
			UNG LI. M.D				n Street.	. Baltim	ore, Mar	yland 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	orks/	21.00			

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician OLURES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) **Examiner** N/A 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs 8. Date of Birth June U3 9. Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Hours 1 □ M 2)X F 59 158-32-4695 **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. tnside City Limits 10b. County or itams 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be notified at 1 Tyes 2 N No Pasadena Director Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21122 606 Lake Shore Drive Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or Itams 23 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Springer Elizabeth. В. Frank J. Citta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James J. Sciubba (spouse) 606 Lake Shore Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. Date 20 20c. Location - City or Town, State Department of H Important: If Ita any injury or ot once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metro Crematory Inc. 2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Stallings Funeral Home, P.A. 21. Signature of Funeral Service Vicent 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 ns have used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use of each line. 23a. Part . Enter the disease, or complic tions shock, or heart failure. List only on Approximate Interval Between set and Death Immediete Cause (Final disease or condition Physician UR ALACH NOI NG /Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. the attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ō Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 2- No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perform 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. 2 Accident 3 T Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. OL OSHVA 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	State of Maryland	Ce	rtificate of	Death_		200	4 01474
51	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Dey Year	3. Time of Death
ian cal	Robert Me	eyer Tucke	er			January	19, 2004	
ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	th	4c. County of De	eath
	28 Bohn Court			Rosed				imore
	5. Social Security Number 6. Se	x 7. Age (In yrs. la ДМ 2□F 4(If Under 1 Year Months Days		. (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	214-84-5201	JM 201	Yrs.			Aug. 27	1963	MD
7	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Le	ocation				10d. Inside City Limits
5								1 ☐ Yes 2 ☒ No
Director	Maryland Baltimo	re l		10f. Zip Code	<u>edale</u>	10	0g. Citizen of What (Country?
٦	28 Bohn Court				21237		USA	,
Funerai	11. Marital Status	12. Was Decedent Ever in U.S	5. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - An	nerican Indian,
FE	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				rto Rican, etc.)	Black, Wh	
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
Completed by	15. Decedent's Edu	reation	16a. Dece	dent's Usual Occu	pation	ocking	16b. Kind of Busines	s/Industry
ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	nd)	n King		
ПO	9			Mechanic	·		Auto)
Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, A	Maiden Surname)	
10	John P. T	ucker			Anna	Coll	nouer	
1	19a. Informant's Name/Relationship (T		19b. Maili	ing Address (Stree	t and Number or R	lural Route Number,	City or Town, State	, Zip Code)
	John P. Tucker	(father)	108	Governor:	s Court,	Apt. C. C	31er Burni	e, MD 21061
1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	20b. Pl	ace of Disponentery, cre	osition (Name of matory or other pla	Jan	Date	20c. Location - City of	or Town, State
	'4 □Donation 5 □ Other (Specify,		ro Cre	ematory I	nc + 20		Baltimore.	Maryland
	21. Signature of Funeral Service Licens		2	2. Name and Addr	ess of Facility			1 Home, P.A.
	Mud. X					ad. Pasad	lena, MD 2	
	23a. Part . Enter the visease, or comp shock, or heart fa ure. List only of	ications that crused the death	. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory arre	est,	Approximate Interval Between
1	Immediate Cause (Final disease or condition	O O	mal	No				Onset and Death
ı	resulting in death)	a. Due to (or as a consequ	ence of))				
	Sequentially list conditions	b						
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discussion of the Indiated events)	Due to (or as a consequ	ence of):					
Examiner	that initiated events	c						
Ä	resulting in death) Last	Due to (or as a consequ	ence of):					
cal		d						
Physician/Medi	IF FEMALE:							70. 72
an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal	death 3[Ectopic pregnanc	;y		23d. Date of d Month	lelivery Day Year
Sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	ath 5[Other (specify)			Month	buy .ou
Phy	9 🗆 Unknown					20a Didaah		to the server of death?
þ	Part II. Other significant conditions co	intributing to death but not resu	iting in the t	ınderiying cause gi	ven in Part I.		Λ.	to the cause of death?
ted						1 □ Ye	s al No 3□I	Probably 4 Unknown
Completed						24a. Was ar autops	y prior to	autopsy findings available completion of cause of
TOU						perform Yes 2	ned? death?	
Be (25. Was case referred to medical examiner?					ath (Check only one	9)	
100	14 Yes 2 □ No	Hospital: 1 Inpatient 2 1	ER/Outpatie	III 3 DOA		Home 5 Reside		oecify) at scene
	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe ho	w injury occurred	4 (0
Certification:	2 ☐ Accident investigation	0/-1-	Uh		Yes 2/17No	subje.	thong	edseld
tiffe	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (5) ecify	me, farm, st	reet, factory, office		28f. Location (Str. City of Town	reet and Number or I	Rural Route Number,
		Un	up	Home		28 Box	N 9.	21237
cai		vsicien: To the best of my know iner: On the basis of examinat						
Medic	(a)	and manner stated.	.cr unworl					
Σ	29b. Signature and title of certifier			29c. Licen	se number		9d. Date signed (Moi	•
	1 Herke	m			O.C.M.E	•	January 20	0, 2004
	30. Name and address of person who o	ompleted cause of death (Item	23а) (Туре	, Print)				
	V- Wen loc	ELMUB	111	L Penn St	reet, Ba	ltimore, 1	Maryland :	21201
tate	31. Date filed (Month, Day Year)	201/32. Tegistrar a Signar	ure	A STATE OF THE PARTY OF THE PAR				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend Item #20b per fh G827 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day Month Year **Physician** January 2200 2004 /Medical 4c. County of Death lity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner last birthday 6. Sex 7. Age (In vrs Birthplace (State or Foreign
 Country) **Funeral** Sex 1□M Months Davs Min Hours Director Usual Residence of Decedent with the Maryland City, Town or Location 10d. Inside City Limits 10a State 10h County 10c. "natural", or items 23e or 28a-f ehow item 27 is marked other then "natural", or items 23s or 28s-f shov other traumatic event, the Medical Examinar must be notified at 1 As 2 No Director 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 20 No 2 ☐ Married □Yes 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Middle : 1 end 2 should be fil Health and Mental H tem 27 ie marked ott Be 19b. Mailing Address (Stre Town, State, Zip Code permit. Pages 1 end 2: Department of Health a Important: if item 27 ie eny injury or other trau 900.8. of Disposition rial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Two days Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Tunknowh ģ peubis 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 90 1 TYes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed peen (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No in by the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 2 2 2004 Registrar

Catherine Meschles:

a Meschelie

140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> Hospital; 201 EUniversity Parkway, Baltimore, IMD Union Memorial 32. Registras Signature

AT2438946-bg

General 14: 3004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. 20 Certificate of Death 2. Date of Death Dav **Physician** JANUARY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner GOOD SAMPARITAN HOSPITAL BALTIMORE Birthplace (State or Foreign
 Countsy) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 1 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. Jorch Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, it is Modical Examinar in ust be notified at once. Mas 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Race - American Indian, 13. Was D Hispanic Origin? (Specify Yes or No-oan, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: δ Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18 Mother's Name (First, Middle, Maide (First, Middle, Last) Method of Disposition 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Eur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE **Physician** RENAI /Medical Due to (or as a consequence of) Examiner CONGESTIVE
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and deedeched for use as the burial-transit HYPOGILYCEMIP that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 3 DOA 2 ER/Outpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOD JANUARY 15 Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ANITHA BY REDDY LOCH RAVEN BLVD, BALTIMORE, MARYLAND 21239 5601 32. Registral Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2.000 legions.

		1 - For State Registrar	State of Maryla				eaith and i Death		giene Z U { Reg. No.	JH UIH/
Physi		Decedent's Name (First, Middle, Last) ROSE WE	CLLANTE					2. Date of De Month	Day Y	'ear 4:05P M
/Med Exam		4a. Facility Name (If not institution, give:		2010	4b. City	11-	Location of Deat	Long	4c. County of	Death
Funera Directo		5. Social Security Number 6. Sey 220-03-2462	01 201111	s. last birthday) 84 Yrs.	If Unde Months	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JUL 4,	th ry, Year) 1919	NA D. Birthplace (State or Foreign Country) PA
yland		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation					10d. Inside City Limits
e Man	Director	MD NA		BAL	TIMO					1 🕅 Yes 2 □ No
with the or 2		10e. Street and Number			10f. Z	ip Code			10g. Citizen of Wha	
21215-0036 I within 72 hours after death with the Maryland liene. Then "natural", or theme 23a or 28a-f show the Mayleal Evarimen must be notified at	/ Funeral	1 X Never Married 2 ☐ Married	AVENUE 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give				21215 spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)		ISA American Indian, White, etc.
hours tural,	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usi	ual Occupa	ition		16b. Kind of Busin	WHITE ness/industry
21215- I within 72 iene. rthan "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of w	ork done d use retired	luring most of wor	rking	ВАКЕ	
ind the filed that Hyger dother event.	To Be C	17. Father's Name (First, Middle, Last)	UNK				18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
re, Maryla s 1 and 2 should f Health and Men item 27 ie marke other treumatic	-	19a. Informant's Name/Relationship (Ty	•	19b. Mailir	ng Addres	s (Street a	and Number or Ru	ral Route Numbe	er, City or Town, Sta	ate, Zip Code)
Hea The		CARLA RANSOM (GUA 20a. Method of Disposition 1 X Burial 2 Cremation 3 CR	20b.	1000 Place of Dispo cemetery, crer	sition (Na	me of	STREET	BALTIM Date	ORE, MD 20c. Location - Cit	21201 ty or Town, State
Iltimor nit. Pages artment of ortant: If it		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentification	I	MT. ZIO		nd Addres	4 = -10-		LANSDOWNI	
Balti permit. Departm importa eny inju				-			V		NERAL HOM IMORE, MD	
Physicia /Medica		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. AMP	ath. Do not ent	er the mo	de of dying	g, such as cardiad	or respiratory and	TON	Approximate Interval Between Onset and Death
Examine	r	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	rosch	eri	otic	Di	sease	Capadari	Years.
68760, tificate be executed g physicien and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	M	elli	tus			Years
death cer death cer e attendir d for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic Other (s	pregnancy			23d. Date o Month	,
rds, P.O quires that the n signed by the	þ	Part II. Dther significant conditions cor	ntributing to death but not re	esulting in the u	nderlying	cause give	on in Part I.			ute to the cause of death?
	Completed							24a. Was autop perfo 1 🗆 Yes 🥎	rmed? prio	re autopsy findings available or to completion of cause of th?
of Vita Physician: this certific rai director.	B	25. Was case referred to medical examiner?	lospital:			Othe	· C	ith (Check only o		
Phys rathis	on; To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		OA 28c. Injury Work	4 🗀 Nursing n		dence 6 Other (now injury occurred	'Specify)
Division of or Attending after death. I Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	M eet, facto		res 2 □ No	28f. Location (5 City or Tov	Street and Number o	or Rural Route Number,
24 hours Funeral	edical Ce	29a. Certifier 1 Certifying Physicians (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death	occurrer vestigatio	d at the tim	e, date and place inion, death occu	, and due to the rred at the time.	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
To the within 2 To the comple	Mec	29b. Signature and title of certifier	and married states.		29	c. License	number		29d. Date signed (A	Wonth, Day, Year)
1		30. Name and address of person who co	MI)	om 23a) /Tac	Priot	000	56418		January	119,2004
1		K. Tonya Mason	MD 240	1 Wes	TB.	elved	ieve Av	e Balt	imore in	为21215
Regis	tate	31. Date filed (Month, Dark Kearl) 2	2004 ^{32. Regulary Sign}	nature /	A TON	a l				

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State of Maryland / Department of Health and Mental Hygiene? [] [] [... Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Vear **Physician** 850 January 20 2004 JOSEPHINE WATKINS Ε. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore HOSPITAL f Under 24 Hrs. Birthplece (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 2 □ F Director 26 3891 76 SEPT.12.1927 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County 28a-f ahow traumatic avant, the Medical Examiner must be notified at 1 Yes 2 □ No MD. N/A BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itame 23s or 915 WILMONT COURT 21202 U.S.A. Josephine Watkins death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 'natural', or Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME 11th HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES HARVEY MARIAN CONTEE 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Importent: If item 27 is
any injury or other trau MARIAN ELLERBE (DAUGHTER) 1811 WOODBOURNE AVE. BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) JAN . 26, 2004 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 Removal from State 4 □ Pohation 5 □ Other (Specify) BALTIMORE NATIONAL CEM. BALTIMORE, MD. ature of Funeral Service Licensee 22 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** loyears /Medical Examiner S- juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ned by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be o Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records. or Attending Physician: this funeral After s after dea. illed in by To the Hospitel o within 24 hours aft To the Funerel DI

State

Medical

27. Manper of Death

2 Accident

4 Thomicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

5 Pending

investigation

determined

6 ☐ Could not be

1 Natural

Registrar

DHMH 17 Rev 1/2001

ROBERT LEG HONE, MV 317

pleted cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

SINAL HOSPITAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

19026

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 20, 2004

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

		For State Registrar		State of	ıvıaryıan 		irtment of tificate of		i Mental Hy	rgiene Reg. No.	2004	0148
Physicia /Medic		Decedent's Name	(First, Middle, La	Viole	t Mary	Wilkins	8		2. Date of Do Month Jan.	Day	2004	3. Time of Death
Examin	_	4a. Facility Name (If		ve street and num ealthco			4b. City, Town,	or Location of De	ire		County of Death Balti	more City
Funeral Director		5. Social Security Nu 215-40-3	3771	Sex 1 □ M 22 F	7. Age (In yrs.	63 Yrs.	If Under 1 Yea Months Days		in. 8. Date of Bi (Month, Di Septemb	^{rth} ay, Ye <i>ar)</i> er 23, 1	9. Birth Cou	place (State or Forei ntry) Maryland
aryland show	7	Usual Residence of 10a. State Maryland	10b. County	Howard	10c. City	y, Town or Lo	cation	Ellicott City				10d. Inside City Limi
with the N a or 28a-f be routh	Directo	10e. Street and Num					10f. Zip Code	2104		10g. Citiz	en of What Cou U.	- '
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status Never Marrie 3 Widowed		12. Was Dece Armed For 1 Tes If Yes, Givi Year or Da	ces? 2 No	"	Was Decedent of Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		4. Race - Ameri Black, White, Specify:	
within 72 ho sne. than "natur re Medical	Completed by		15. Decedent's E fy only highest g idany (0-12)		-4or 5+)	(Give	DO NOT use retir	e during most of t		16b. Kin	d of Business/Ir Social	Services
ental Hygie ked other ic event, L	To Be Co	17. Father's Name (I	t) les Shaeffei	lame (First, Middle Virg		_{Sumame)} nia Wilkins						
aith and M 27 is mar r traumat		19a. Informant's Na Mrs. V	me/Relationship iola Kirklan		Sister				Rural Route Numb ahan, Florida		Town, State, Zi	o Code)
nent of Hea ant: If item ury or othe		20a. Met/lod of Disp 1 Surial 2 ☐ 4 ☐ Donation	Cremation 3	□Removal from \$	State 20b. P	-	sition <i>(Name of</i> natory or other pl Shepherd Co		Date 01/24/2004	20c. Loc	ation - City or T Ellicott Cit	own, State ty, Maryland
Departr Importa any inju		21. Signature of Fun	peral Service Cic.	Mole	Mola	JB 22	Name and Add Slac 3871	ress of Facility K Funeral H I Old Colum	ome, P.A. bia Pike Ellic	ott City	, MD 21043	3
/sician		23a. Part1. Enterth shock, or hear Immediate Cause (I disease or condition	Final	riplications that ca y one cause on ea	aused the death	n. Do not ente		ying, such as card		arrest,		Approximate Interval Between Onset and Death
Medical Examiner projection with private and private into	<u></u>	resulting in death) Sequentially list con	ditions.	b	or as a conseq Meto	astate	i to	lev	in			
	ai Examiner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
igned by the attending phys be detached for use as the	Physician/Medical	in the past 12 i	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No									ery Day Year
ν τ	5	Part II. Other signifi	cant conditions	contributing to de	eath but not res	ulting in the ur	nderlying cause g	given in Part I.		tobacco us		the cause of death?
certificate has been rector, page 2 shoule	Completed								24a. Was auto perf 1 ☐ Yes		24b. Were auto prior to co death? 1 \(\superscript{\text{Yes}}\)	opsy findings available on pletion of cause of
After this uneral di	To Be	25. Was case referrexaminer? 1 Yes 2 7. Manner of Death 1 Natural	No	28a. Date of		ER/Outpatien 28b. Time of Injury	28c. Inj	ther: 4 🗆 Nursin	Death (Check only g Home 5 \sum Res 28d. Describe	idence 6		fy)
after death	Certification:	2 Accident 3 Suicide 4 Homicide	6 ☐ Could not determine	be 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, str	eet, factory, office			(Street and wn, State)	Number or Run	al Route Number,
within 24 hours a To the Funeral i completely filled	Medical C	29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	Physician: To the aminer: On the ba and mann	asis of examina	wledge, death tion and/or inv	n occurred at the restigation, in my	time, date and play opinion, death of	ace, and due to the courred at the time	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
To th	Ň	29b. Signature and	Bul	t	gical h	lesident		SA 243852	8-3526		signed (Month,	* 1
		30. Name and addre	45	Baralu	50		Print) Paul	st # 12	8-3526. 06 Ba	Homn	np	21202
Sta Registi		31. Date filed (Mont	th, Day, Year)	2 2004 D	egistrar's Signa		South .	,				

ORIGINAL

			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygie	
	Physic /Medi Examii	cal	4a. Fecility Name (If not institution, give 5330 Dorsey Hall	oh V. Zander street and number)	4b. City, Town, or Location of Dea	JAN. 21	Day Year 2004 7:25p M 4c. County of Death Howard
	Funeral Director		5. Social Security Number 047-09-5331 6. Se Usual Residence of Decedent	x 7. Age (In yrs. last b	Yrs. H Under 1 Year If Under 24 Hr Months Days Hours Mir		ear) 9. Birthplace (State or Foreign Country) New York
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event. If a Medical Examinar must be notified at ODGs.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Howard 10e. Street and Number 5330 Dorsey Hall 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Clarence Stanley 19a. Informant's Name/Relationship (T) Gerda Helene Zand 20a. Method of Disposition 1 Burial 2 Moreation 3 F 1 Donation Other (Specify)	Drive #323 12. Was Decedent Ever in U.S. Armed Forces? 1 To Yes. 2 To No II Yes. Give Year or Dates: Cation e completed) College (1-4or 5+) 4 Zander pe, Print) er/Wife 20b. Place of Commette	Nathali b. Mailing Address (Street and Number or R 5330 Dorsey Hall Driv of Disposition (Name of ary, crematory or other place)	Descript Yes or No- ric Rican, etc.) The pricing of the pricing o	14. Race - American Indian, Black, White, etc. Specify: White . Kind of Business/Industry Partment Defense den Sumame)
	Physician /Medical Examiner	ai Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any locating to temperature or cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do the cause on each line. Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	of):	ad Baltım	C. Ore, MD 21228 Approximate Interval Between Onset and Death
P.O. Box 6	law requires that the death centificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions con	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown tributing to death but not resulting in	5 Other (specify)	23e. Did tobacc	23d. Date of delivery Month Day Year Duse contribute to the cause of death?
al Records,	The ate h page	Completed				1 Yes 24a. Was an autopsy performed? 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital	ding Phys n. After this funeral di	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No		utpatient 3 DOA Other: 4 Nursing H Time of Nursing H Other: 4 Nursing H Other: 4 Nursing H Other: 4 Nursing H Other: 4 Nursing H Other: 4 Nursing H Other: 4 Nursing H Other: 4 Nursing H	28d. Di scribe how in	and Number or Rural Route Number.
- V	To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of centifier	and manner stated.	e, death occurred at the time, date and place d'or investigation, in my opinion, death occu	rred at the time, date a	ate signed (Month, Day, Year)
	Sta Registr	te	30. Name and address of person was conclement B. Knight, 31. Date filed (Month, Day, Year)		(Type, Print) tle Patuxent Parkway	Columbia,	, MD 21044

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month **Physician** Robert William Allen Jan. 10 2004 12:30pm /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, give street and number) Examiner 304 Third Street Marydel Caroline 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 4-30-1933 Birthplace (State or Foreign Country) 6 Say 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 137 M 2 □ F 70 218-30-6708 Delaware Director Usual Rasidance of Decedant Peges 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mentel Hygiene. nt: If Item 27 is marked other then "natural", or items 23a or 28a-f ahow 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 1 □XYas 2 □ No Caroline Marvdel Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Third Street 21649 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑Yas 2 ☐ No If Yes, Giva 14. Race - Amarican Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Yaar or Datas: el Hygiene. d other then "natura event, the Medical E Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Yard foreman Building supply 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Be Clarence Allen Martha Kemp 2 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health er important: If item 27 is any injury or other trait once. Delsie L. Allen -- wife 304 Third St., Marydel, MD 21649 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.14 Olive Cemetery Sandtown, DE 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility 19934 Pippin Funeral Home 23a. Part1. Enter the disaasa, or complications that causad the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest,

Approximate Approximata Interval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Dua to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires thet the deeth certificate be executed Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Dua to (or as e consequence of) Completed by Physician/Medical 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No † ☐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa SX Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident 5 ☐ Panding 1 ☐ Yes 2 X No death. invastigation Director: A 6 Could not ba 3 ☐ Suicida Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida efter within 24 hours eff
To the Funeral Di
completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, daath occurred at tha time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier to complated cause of deth (Iten 23a) Type, Print) and address of pers 215 Old Town Road AHZIBELDO 32. Registrar's Signatura 31. Data filed (Month, Day, Year) Registrar

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	ryland / D)epa	artment of H	lealth and M		- 40	01483
			Registrar 1. Decedent's Name (First, Middle, La.	net)		Cei	unicate of	Deain	Reg 2. Date of Death	ı. No.	3. Time of Death
Н	Physici	an	feel and						Month	Day Year	
	/Medic		Sterling 4a. Facility Name (If not institution, give		Atchis	n	4h City Tourn o	r Location of Death	January	3, 2004 4c. County of Dec	6:15 P.M
	Examin	er		·						•	
	Funeval		Manor Care of Pot 5. Social Security Number 6. S		(In yrs. last birt	hday)	Poton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgon 9. Bi	rthplace (State or Foreign country)
	Funeral Director			□M 2131F	76	Yrs.	Months Days	Hours Min.	(Month, Day, Y Nov. 11,		country) rginia
			Usual Residence of Decedent						11000 119	1)21 V3	I SILLA
	nylan how		10a. State 10b. County		10c. City, Town	or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Montgome	ery	Pot	oma	ac				1 ☐ Yes 2 ☒ No
	ith th	Dire	10e. Street and Number				10f. Zip Code		10g	. Citizen of What C	country?
	ath w	ral	9908 Barstow Cour	T			208			nited St	
	er de Items	nne	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Decedent of H f Yes, specify Cuba	tispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show he Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0		1 ☐ Yes 2 🛣 No	Specify:		Specify:	7. 4
21215-0036	hou stura		15. Decedent's Ed		16a.	Dece	dent's Usual Occup	ation	16	b. Kind of Busines	hite s/Industry
15	nin 72 n "ne Medik	Completed	(Specify only highest gra	de completed)		(Give		during most of work.	ing		,
212	with piene r the	mo	Elementary/Secondary (0-12)	College (1-4or 5- 5+		sic	al Scien	ce Admini	strator D	epartment	of Defense
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lar	d Mental marked o	ToE	Neal (Clark					Mattie	Jorda	.n
Maryland	s ma	. 1	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailir	ng Address (Street	and Number or Rura	al Route Number, C	City or Town, State,	Zip Code)
	and 2 salth n 27 i		Charles M. Atchiso	on/Husband				Court, Po			20854
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter	Dispo y, cren	sition (Name of natory or other plac		Date 20	c. Location - City o	r Town, State
<u>Ĕ</u>	Pag ment: I		'4 □Donation 5 □ Other (Specify		All So	u1s	Cemeter	y 1/9/	2004 Ge	rmantown	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	-	21. Signature of Funeral Service Licer	A Luc	lle		. Name and Addre	Dev	ol Funera		m 20077
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do n			er Park D			Approximate
B	40000		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	θ.		-,	3,		,	Interval Between Onset and Death
	Physician / /Medical	W)	disease or condition resulting in death)	a Stroke		Α.					
	Examiner				consequence of	or):					
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	uted d ansit	mi	cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ.	icate be executed physician and s the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	consequence	of):					
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Θ			IF FEILING			11-					
Box	death certifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy 2 Fetel death	3□	Ectopic pregnancy	,		23d. Date of de	
	0 0 0	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at t			Other (specify)			Month	Day Year
P.O.	that the de ned by the a detached f	Phy	9 Unknown						no. Didustri		
Ś	Se 25 9	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the ur	iderlying cause giv	en in Part I.			o the cause of death?
ord	w require been si should I	ted							1 Tes	2 100 3 1 5	TODADIY 443ONKNOWN
Record	law lasb	Completed							24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>~</u>	ding Physicien: The lav h. Atter this certificate has funeral director, page 2.	Con							performe 1 ☐ Yes 218	d? death? No 1 ☐ Ye	s 2□ No
of Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		-	Oth	or	(Check only one)		
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	ding After funer	lo lo	1 ☑ Natural 5 ☐ Pending	(Month, Day	Year) In	njury	Wor	yat k? Yes 2 □ No	ZOU. DESCRIBE NOW	injury occurred	
Division	Attending or death, ector: After by the fune	lica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		rv - At home, fai	m str			28f. Location (Stree	at and Number or R	ural Route Number,
Š	afor after Dire	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	,			City or Town, 5	State)	
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	ro the vithin 2 of the complet	Med	29b. Signature and title of certifier	and manner stat	ed.		29c. Licens	e number	29d	Date signed (Mon	th, Day, Year)
				~ / U~~			D 5	1280	Jai	nuary 5,	2004
	> .		30. Name and address of person who				Print)				
	Sta	te	Anushiravan Dadga: 31 Date filed (Month, Day, Year)	32. Registra		<u>L</u>			Germanic	JWII PID.	20074
	Registr		JAN 0 7 20	04 Sene	me /	7	Spark	/			

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	Physici	an	Decedent's Name (First, Middle, Las							 Date of Death Month 	Day	Year	3. Time o	
	/Medic			SKINS						JAN.	Day 20	04	7:31	LΑM
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town				4c. County	or Death		
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	Funeral Director		5. Social Security Number 6. Social Security Number 578-14-5264	M 2 □ M 2 □	7 2	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day, Sept. 2	, 1931	9. Birth Cou Ma	place (State Intry) LTYLar	or Foreign 1d
	and wa		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside C	City Limits
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	the 28s	rec	10e. Street and Number		1		10f. Zip Code			10	g. Citizen of \	What Cou	intrv?	
	3a or	ō	101 Odendhal	Ave.,	#402			0877			U.:	S.A.		
	death	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. \	Vas Decedent o	f Hispanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,	
9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2]X] If Yes, Give		i	Yes, specify C □ Yes 21 10 1			Hican, etc.)		k, White,	_	
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ano	0 = 0 >) Be	Jacob Martin					10.141001		arrie G		16/		
<u></u>	should and Men marks umarks	ဥ	19a. Informant's Name/Relationship (7	voe. Print)		19b Mailin	n Address (Stre	et and Numb		l Route Number,		State Zir	n Code)	-
Maryland 21215-0036	and 2 sealth ar n 27 is ner trau		Mary Hebron (S			1				Gaith				20877
5	a =		20a. Method of Disposition		20b. P		sition (Name of natory or other p				0c. Location ·			
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Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Skyrature of Ferral Service Licen		1					OWDEN :			•	.A.
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P.O. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnar Other (specify)	ncy			23d. Dat Mor	e of delive	*	Year
Records, P	sign d be	ρ	Part II. Other significant conditions or	entributing to death b	out not resu	ulting in the un	derlying cause	given in Part I	l.		icco use contr 2 ⊋ No		he cause of c pably 4 □l	
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ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one	F18.			
<u>></u>	hysic his ce	၉	1 ☐ Yes 2√2 No	Hospital: 1 ☐ Inpatio		ER/Outpatient	3□ DOA	Other: 4 🖾 Nu	ursing Hon	ne 5 🗆 Residen	ce 6 □Othe	er (Specif	y)	
Division of Vital	After fune	ation:	27. Manner of Death 1 ☒ Natural 2 ☐ Accident 5 ☐ Pending investigation	28a. Date of Inju (Month, Da	iry y Year)	28b. Time of Injury	28c. In W	jury at ?ork? □ Yes 2 □	2	28d. Describe how				
Divis	tal or Attencis after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	ury - At ho c. (Specify	me, farm, stre	et, factory, offic	в	2	28f. Location (Stre City or Town,		er or Rura	<i>l Route Nu</i> m	ber,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best iner: On the basis o and manner st	f examinat	wledge, death tion and/or inv	occurred at the estigation, in my	time, date an opinion, dea	nd place, a th occurre	and due to the cau ed at the time, dat	se(s) and ma e and place, a	nner as si	tated. the cause(s)
ì	To the vithin To the comple	Σ	29b. Signature and title of certifier	SHAM	IM	*		59284		296	Jan.			
			30. Name and address of person who c	ompleted cause of c										
			Shahid Shami: 31. Date filed (Month, Day, Year)	M.D. 32. Registr	129	99 Lan	bertor	n Driv	7 9 ,	Silver	Sprin	g, I	MD 20	902
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Year 935 AM **Physician** 04 · /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death **Examiner** RIHaB Annapolis Nursing and 5. Social Security Number 6. Sex Annapolis Anne Arundel if Under 1 Year 8. Date of Birth (Month, Dey, Yeer) May 1,1923 If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) U.S.S.R. 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛛 F 80 154-26-9414 May Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylend Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic evant, the Medical Examinating mat be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits TX Yes 2 □ No Md Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 900 Van Buren Street 20715 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stefan Kolotilo Anastasia Kovalenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Igor Baumann/Son 13200 Yorktown Road Bowie, Md. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/04 4 ☐ Donation 5 ☐ Other (Specify) East Ridgelawn Cem. Clifton, New Jersey 21. Signature Funeral Service Licens PHILIP D.RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the rise ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Hour failur /Medical Immediate Cause (Final disease or condition resulting in death) Examiner pertersion Physician/Medical Examiner physician and s the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter death. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant-conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yee 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No Medical Certification: To efter death.

I Diractor: After this ed in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D 1 Natural er of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funaral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0110712004 for tod cause of death (Item 23a) (Type, Print) 30. Name and address of pers in who c Choord 600 Ridgely Ave Suite 231 Amapais, n.D. 2140 Aditua 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 09 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JANUARY 2, 2004 13:25 ROY ALLEN BECKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE MONTGOMERY CASEY HOUSE 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1(**3**M 2□ F Director 132-20-3207 73 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10d, Inside City Limits 10a State 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND MONTGOMERY **POTOMAC** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 20854 11711 GREENLANE DRIVE U.S.A. Items 23e permit. Pages 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hydene. Important: If Item 27 is marked other than "natural", or items 23 may injury or other traumatic event, Ira Madical Examinat must once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: KOREAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 INSURANCE AGENT INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOUIS BECKER ELLA FELS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11711 GREENLANE DRIVE, POTOMAC, MARYLAND 20854 ELAINE D. BECKER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) JANUARY 2004 MT. LEBANON CEMETERY QUEENS, NEW YORK 21. Signature of Funeral Service Dicensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 20852 Approximate Interval Between Conset and Death MONTHS 23a. Part. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC RENAL CELL CARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2X No 26. Place of Death (Check only one) 25. Was case referred to medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES HARRISON, 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 7 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** Brinkle Janoar 3:500: 12 2004 /Medical b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 'ocomoke Worcester If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 i (In yrs. last birthday) 5. Social Security Number 7. Age **Funeral** 1 ☐ M 2 🖫 F 02 220-01-6583 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City_Town or Location 10a. State 10b. County d other than "natural", or Items 23s or 28s-f show event, the Medical Examiner must be notified at 1 √Yes 2 No Director ocomoKe Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S 21851 1006 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event. In a second of the contract of the c Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Jack 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Senfood Laborer 6th avado 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Sarah Cottingham 19a. Informant's Nama/Relationship (Typ , rint) Biveus Neice Salisbur Colonia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Sta 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04 Marion Station Md 4 Donation 5 Other (Specify) of. 21. Signature June al Service Licensee and Princess 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ap roximate Interval Between Onset and Death Exterio sele Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to influe diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner spitel or Attending Physicien: The law requires that the death certificate be executed rours after death.

nerel Director: After this certificate has been signed by the attending physicien and rilled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significent conditions contributing to death out not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C completely filled in To the Hospitel 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 29505 geres tori 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 1 4 2004

32. Registrar's Signature

			1 - For State Registrar	State of Marylan	d / Depa	artment rtificate	of H	ealth a Death	and M		jiene2 0	04	* Anny p	388
			Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time o	f Death
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	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, 1	Fown, or	Location of	f Death		4c. County	of Death		
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	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow the Madical Examina must be notified at	Funeral	9004 Bramble Bush	2. Was Decedent Ever in U	.S. 13.				gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	e - Ameri	ican Indian,	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Mardical Examinar must be notified at once.		21. Signature Funeral Service License		F:	rancis 00 Un	d Addres S J. iver	Coll Sity	ins Blvd	Funeral . W. ,S	Home I	nc.	g, MD	20901
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			State of Maryland / 1- State Registrar	Depar		of H	ealth a	and M	ental Hyg	_		0	89
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea		.,	3. Time of	Death
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, T	own, or	Location of	of Death		4c. County			
			Althea Woodland Nursing Home		Si	lver	Spr	ing		Mont	tgome	ry	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	olece (State or	r Foreign
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36	s aft	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes, Give A 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10	Yes 2	No No	Specify:			Specify	· Wh	ite	
8	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28e-f show that the Medical Examiner must be notified at	pa		a. Decede	nt's Usual	Occupa	tion			16b. Kind of Bu			
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<u>a</u>	id be ental ked o	To B	Charles F. Bradley				Cai	rol A	. Owens				
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (Type, Print)	b. Mailing	Address (Street a	nd Numbe	or or Rural	Route Number	, City or Town,	State, Zip	Code)	
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show wenty intry or other treumatic event, the Madical Examiner must be notified at ODGs.		Carol A. Bradley (Mother)	1270	7 Ho	ldri	dge I	Rd.,	Silver	Spring,	Md.	20906	
Baltimore,	of He and M		20a. Method of Disposition 20b. Place cemet	of Disposit	tion (Name	e of	1 1			20c. Location -	City or To	own, State	
Ê	Page ent o ent o ry or		Burial 212 Cremation 3 Removal from State	apeak			10	200	ry 7, 4	Beltsv	zille	. Md.	
≣	artm orter injun		21. Signature of Funeral Service Licensee/	22.1	Name and	Address	s of Facilit	y					
ä	Ded presented by the control of the		Busin O Abroday capie (1)	R	Rapp 133 G	Fune ist	ral a	and C	rematic	n Servi	ces	010	
			23a. Part1. Enter the disease, or complication, that caused the death. Do shock, or heart failure. List only one cause on each line.								1. 20	Approximate Interval Bety	
٠,			Immediate Cause (Final				-					Onset and D	eath
	Pnysician /Medical		disease or condition resulting in death) a. Pneumoni Due to (or as a consequence								-	1 Wee	k
	Examiner		Huntingto		Char	0.0						20 Yea	
		ē	Sequentially list conditions, if any, leading to immediate cause after throughout the consequence cause after throughout the consequence cause.		CHOI	ca						zu iea	LS
	uted I Insit	Examiner	Cause (Disease or injury										
<u>,</u>	exector and and ial-tra	Exa	resulting in death) Last C. Due to (or as a consequence	e of):									
760,	ate be executed hysician and he burial-transit	cal	d								100		
89	leath certificat attending phy I for use as th												-
Box	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat	h 2∏⊑	ctopic pre	002004					e of delive	•	
	deatl e atte	icia	1 Vas 2 No 4 Pregnant at time of death		Other (spe					Mor	nth	Day Y	ear
Ö.	that the de the by the a detached f	hys	9 ☐ Unknown	_		-							
o.	res tha igned be del	ру Р	Part II. Other significent conditions contributing to death but not resulting	in the und	lerlying cau	use give	n in Part I.			acco use contr	ibute to th	ne cause of de	ath?
ğ	w require been slig should b				-				1 □ Y€	s 2 No	3 🗌 Prob	ably 4 □U	nknown
ပ္တ	aw re	Completed							24a. Was a autops	24b. V	Vere auto	psy findings a npletion of ca	vailable
Ž.	The law cate has page 2	E							perform 1 XYes 2	ned? d	eath?		u56 01
of Vital Records,		Be C	25. Was case referred to medical				26. Place	of Death	(Check only on			720	
\leq	ysici is cer direc	0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient	3□ DOA	Othe	4 Nu	rsing Hom	e 5 🗆 Reside	nce 6 Othe	r (Specif	1)	
	Attending Physicien: or death, ector: After this certific by the funeral director,	T :U	Adapth Cay Vocal	Time of Injury	28	c. Injury Work	at	2	8d. Describe ho	w injury occurre	ed		
0	ath. r: Aff	atio	2 Accident investigation		M		es 2 🗆 N	No					
Division	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	farm, stree	et, factory,	office		2	Bf. Location (St City or Town	reet and Numbe , State)	or Or Rura	l Route Numb	er,
Ξ	rs aft al Di ed in	Certification:						TI.					
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only (Ch	ge, death o	occurred at	the time	e, date and	d place, a	nd due to the ca	use(s) and mai	ner as st	ated.	
	the F nin 24 the F nplete	Medical	one) and manner stated.	2. 3.170	77								
	with To 1	Σ	29b. Signature and little of certifier			License			2	9d. Date signed			
	2		Huch Gillet	_)2190	00			Janua	ry 4	, 2004	
			30. Name and address of person who completed cause of death (Item 23a)				_						
			Smith Ho, M.D.; 7610 Carroll Ave.,	#280	, Tak	toma	Park	, Md	<u> </u>				
	Sta Registr		31. Date filed (Month, Day, Year) 1.1. N. O. G. 2004	9	Spa	de	<i>j</i> .						
	negisti	खा	JAN 0 6 2004 Server	- /	1								

			1 - For State Registrar	State of Mar	ryland / Depa <i>Cei</i>	artment of H tificate of			giene 20 (04 01490		
F			1. Decedent's Name (First, Middle, Last))				2. Date of Dea	Day Ye	3. Time of Death		
	Physici /Medio		John (Owen	Brady			January	1 0001	6:14 PM		
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of Deeth			
			16813 Oak Hill Roa	ad		Silver	Spring		Montgo	omerv		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			h 9.	Birthplece (Stete or Foreign Country)		
	Director		577 - 07 - 8556	M 2□F	93 Yrs.	Worters Days	Tiodis William			Washington, DC		
	P		Usual Residence of Decedent					10.00		Land Annie Challing		
	show	-	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
	9 Ma	Director	Maryland Montgom	ery	Silver S	pring			.=			
	or 28	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?		
	th wi		16813 Oak Hill	Rd.		209			USA			
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Vas Decedent of F f Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl	ipecify Yes or No- to Rican, etc.)		American Indian, White, etc.		
õ	or it		1 Never Married 2 Married	1 ∑Yes 2 No If Yes, Give	000 00	I ☐ Yes 2x ☐ No	Specify:		Specify:	White		
Š	72 hours after death with the Maryland "natural", or items 23a or 28e-f show idical Exeminer must be notified at	d by	3 XWidowed 4 Divorced	Year or Dates: 1	933-39							
9500-51212	nati	Completed	15. Decedent's Edu (Specify only highest grade		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business/Industry			
2	within 72 ene. than "nath	m	Elementary/Secondary (0-12)	College (1-4or 5+))							
	a H in		17. Father's Name (First, Middle, Last)		T	eletype l		me /First Middle	News S Maiden Sumame)	ervice		
Maryland		Be					10. WOUTER 3 144	no (r nat, madro,	maidon damano,			
	as 1 and 2 should be of Health and Ment iftem 27 is marked rother traumatic a	Lo	Howard Brad			Edna Broo		to Tip Code l				
ā	2 sh and le rr		19a. Informant's Name/Relationship (Ty		Number, City or Town, State, Zip Code)							
Baltimore, N	and leaith m 27		Linda Lingan/ Dau	ghter	20b. Place of Dispo	3 Oak Hi	11 Ed., S	Silver Sp	oring, MD	20905		
	T item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	ary 7	20c. Location - Cit	y or Town, State						
	Pages ment of ant: If it		' 4 ☐ Donation 5 ☐ Other (Specify)		Ceme	nabus Chu etery	2		Temple Hi	ills, MD		
	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service License	80	22 F1	Name and Addre	ss of Facility Collins	Funeral	Home Inc	•		
	20229		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	Joseph T	50	00 Univer	rsity Blv	d. W.,	Silver Sr	oring, MD 2090		
8760,	Physician /Medical Examiner the parial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	jenne	R'S [) S	3 C	Onset and Death		
.O. Box 6	death certifi e attending l ed for use as	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tii 9□Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	f delivery Day Year		
ecords, P	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the ur	nderlying cause giv	ven in Part I.			te to the cause of death? Probably 4 □Unknown		
S	w require been si should	Completed						24a. Was		e autopsy findings available		
Ě	o	m							rmed? deat			
	ilcien: Th certificate rector, pag	e Co	25. Was case referred to medical				00 Disease (Day	1 Yes	- 2	Yes 2□ No		
Vital	Physicien: this certific ral director,	o Be	examiner?	Hospital:	t 2 ☐ ER/Outpatien	t 3 DOA Ott		ath (Check only o	lence 6 Other (Consti		
on of	D 0 0	1-	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time of	28c. Inju	ry at		now injury occurred	э <i>рөспу)</i>		
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
	ne Hospii n 24 hour ta Funari	edical (sician: To the best of ner: On the basis of e and manner state	xamination and/or inv							
	To the within To the Comp	Σ	29b. Signature and the of certifier			29c. Licens	se number		29d. Date signed (N	fonth, Day, Year)		
			/ Val_ / ja	elles	Tro	D24	4093		January 6	5. 2004		
	1241		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type,					.,		
			Dr. Mark Parkhurs	t M.D. 5	711 Sarvis	Avenue,	Riverda	le, MD	20737			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar		,						
	Registi	rar 🕆	JAN 0 7 200	14 Deper	1	Spark	2					

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** ELIZABETH RHODES BREDICE 2004 1, January 1:30pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2XF 579-18-9631 85 Yrs May 2, 1918 Washington D.C. Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Heelth and Mentel Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Md. Montgomery Gaithersburg Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9614 Duffer Way 20879 items 23a United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Yes 2 No Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Dependent of Heelth and Mente important: If Item 27 is marked any Injury or other traumatic events in the context of the conte Joseph Lee Rhodes Myrtle Magoon 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9614 Duffer Way Gaithersburg, Md. 20879 Don F. Bredice -Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Jan.6, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Acute Myocardial Infarction Minutes Examiner Due to (or as a consequence of) Physician/Medical Examiner Atherosclerotic Coronary Artery Disease Years Attending Physician: The law requires that the death certificate be executed bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by sete hes been signe pege 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TL Yes 2 X No 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: Medical Certification: To 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò To the Hospital o within 24 hours ef To the Funeral DI 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 170028025 0 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Jonathan Wenk M.D. 9901 Medical Center Dr. Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2004 Registrar

				1 - For State Registrar	State of I	Marylan		artmen rtificat			and M	ental Hy	giene 2 (004	01492
		D		1. Decedent's Name (First, Middle, Last)		-						2. Date of De	aath Day	Year	3. Time of Death
1	300	Physici /Medic			m Ira B		1					Januar	y 10, 2	004	12:50 p ^M
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		Funeral Director		5. Social Security Number 6. Security Number 220-20-9309	M 2□F	72	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Sept. 1	Ψ, _{Year)} 2. 1931	9. Birthi Cour Ma	place (State or Foreign http) ryland
2				Usuel Residence of Decedent											
		anylan show	_	10a. State 10b. County	•	10c. Cit	y, Town or Lo		+ D-						0d. Inside City Limits 1 ☐ Yes 2 🖾 No
17		the Maryla 28a-f shor	ecto	Maryland Ceci	<u> </u>			10f. Zip		posit	-		10g. Citizen of V	What Cour	
		with t	급					TOI. Zip		1904				J.S.A	•
3		heath w	eral	118 Theodore Road	12. Was Decede	nt Ever in U	.S. 13. 1	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		e - Ameri	can Indian,
B	9	or Iter	by Funeral Director	1 ☐ Never Married 2 🕅 Married	Armed Force	□No		lfYes,speo 1⊡Yes :			, Puerto I	Rican, etc.)		k, White,	
William	003	within 72 hours after death with the Maryland ane. then "natural", or Items 23s or 28s-f show the Maryland Experience of the confidence of		3 Widowed 4 Divorced	If Yes, Give Year or Date	s: 1952	-54						Specify		White
5	15-	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation <i>luring m</i> ost ')	t of workin	ng	16b. Kind of B		ing Ground
7	12	withii iene. then	omp	Elementary/Secondary (0-12) Twelve Years	College (1-40	or 5+)	1.7	lectr							Maryland
	þ	e filed wi Il Hygien other th	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden Suman	(e)	
2	/lar	should be filed withing Mental Hygiene. marked other then matte event, ILEM	TOE	Ira J.	Brannan								Campbe		
rannan,	Baltimore, Maryland 21215-0036	2 8 8 T		19a. Informant's Name/Relationship (Ty Shirley J. Brannar			1	•					er, City or Town, sit, Mar		•
S	e, l	1 and 2 Health Iem 27 I		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	Ī		ate	20c. Location -		
ST	ē	ages int of t: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	ite C	emetery, crer opewe1	matory or o	ther plac		01/1	4/04		·	t, Maryland
(4)	ij	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other once.		21. Signature of Funeral Service License	•	35	22	Name an	d Addres	s of Facilit	v			•	
	ä	Depa Impo any is		Monrow M. t	attera	2,13							neral Ho 03-0766	me,	P.A.
_				23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that cause on each	sed the deet h line.									Approximate Interval Between
7		Physician		Immediate Cause (Final disease or condition			5	eps.	25						Onset and Death 3 days
-011		/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	,							,
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	9 ×	The law requires that the death certilical ale has been signed by the attending phy bage 2 should be delached for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcor	ma of orogn	nov.								
I	.O. Box	attend for us	ian	in the past 12 months?	1 □ Live birth	2 Feta	death 3	Ectopic pr					23d. Dai	e of deliventh	ery Day Year
7	o.	t the de by the a	ysic	1 Yes 2 No	9□ Unknow			2 04101 (0)	Jony)						
0	O .	es that igned b be deta	by Pl	Part II. Other significant conditions con	tributing to deat	h but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco use cont	ribute to tl	ne cause of death?
6	rds	v require been sig should b	ed t		F	neur	nonit	٤				1 🗆	Yes 2□No	3 ☐ Prob	pably 4 Unknown
	Records,	e law requ has been je 2 shoul	Completed		1-	temo	physi	ک				24a. Was	psy p	rior to co	psy findings available mpletion of cause of
3		: The l	Con	<i>F</i>	igper (roag	ulabi	lity	Sy	indn	mo-	perfo 1 ☐ Yes		leath?	2□ No
	Vita	Physicien: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	lospital:	0			Othe	ar.		(Check only o			
	Division of Vital		. To	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of I	niury	ER/Outpatier 28b. Time of	_	8c. Injury Work	4 🗆 1401	-		dence 6 00th how injury occurr		y)
7	ion	Attending I r death. octor: Alter by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	М		(? Yes 2 □1	No				
0	vis	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building.	Injury - At he	ome, farm, str	eet, factory	, office		2	8f. Location (Street and Numb wn, State)	er or Rura	il Route Number,
3/6		itel or irs afte ral Dir lled in	Cer												
110		Hospitel 24 hours a Funeral stely filled	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami		s of examina									
1		To the Hospitel or Atta within 24 hours atter de To the Funeral Directo completely filled in by th	Mec		22AA		6 M	290	. License	number			29d. Date signed	(Month,	Day, Year)
		⊢ ≴ ⊢ ō		1/5209 /1/11	46/11/	13/11	v) //(D4	+3/15	5		1-11-	-04	4
		5 + IVA		30. Name and address of person who co	mpleted cause of	of death (Item	n 23a) (Type.	Print)				1 7	2107		
	_) . 101		615, S. Union	Ave,		se d	e 0	22	ce	, 10	10 >	210/	8	
		Sta Registi		31. Date filed (Month, Day, Year) JAN 13 2004	32. Hegi	istrar's Signa	logali >								

DHMH 17 Rev 1/2001

			1 - State Registrar Amend Item	State of M #5 per fl	aryland n G827	1/Pepa Cer	rtment 104 tificate	of H	ealth ar D <i>eath</i>	nd Menta	al Hyg	iene 2	004	01493	
	Physici		Decedent's Name (First, Middle, Last) John	tte				_ Mo	te of Deat onth	Day	Year	3. Time of Death 11:43PM			
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, 1	Fown, or	Location of I		racity	4c. County of Death			
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	Funeral Director	-	5. 341 375-1 6. Sept. 409-24-9045	7. Ag	e (In yrs. Ia 91	Yrs.	If Under Months	Days	Hours Hours	Min. (Mi	te of Birth onth, Day, 4	Year) 1912	Co	hplace (State or Foreign untry) Orida	
	p and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	cation							10d. Inside City Limits	
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	28a-	Director	Maryland Tillice Ge	orde 2		FOLL V	10f. Zip		[1		1	0g. Citizen o	f What Co	untry?	
	h with	ai Di	8322 Allentown R	oad			207	744				U.S.A.			
	ams ?	Funerai	11. Marital Status	12. Was Decedent Armed Forces?			Vas Decede	ent of Hi	spanic Origin	n? (Specify Yo	es or No-	14. Ra		nican Indian,	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Mestical Eraminer must be mollited at	by Fu	1 Never Married 2 Marned 3 XWidowed 4 Divorced	1 □ Yes 20X If Yes, Give Year or Dates:			□Yes 2		Specify:		,			White	
215-0036		ted	15. Decedent's Edu			16a. Deced				of wasting		16b. Kind of	Business/l	Industry	
21		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use	e retired,		or working		Constr	uctio	an .	
2	led willygien ther the		4th			I	Iron W	vorke		a Blace - /Fine				Л1	
and	e dai	To Be	17. Father's Name (First, Middle, Last) John Robinso	on Boyett	e				Mary	s Name (First,	Сос		ıme)		
Maryland		-	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	g Address	(Street a	nd Number	or Rural Rout	Number,	City or Town	n, State, Z	Tip Code)	
			Wynton Boyette 20a. Method of Disposition	(Son)	20b. Pla	8322 ace of Dispos	Aller	ntown	1 Poad	Fort	Washi	ngtor 20c. Location	. MD	20744	
100			1 XX urial 2 ☐ Cremation 3 ☐ F		се	metery, crem	natory`or oti	her place	` ¦Ja	^{an} 2084	'	200. EUGANOI	- City of	iowii, State	
altimore,	artme ortant injury		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Funeral Service Ligens		She	lby Hi	lls C	emet Addres			uner	risto	TN)C-	
B	Depa Impo any in		21. Signate of Funeral Service Licensee 22. Name and Address of Ficility Lee Funeral 6633 Old Alexandria Ferry Ro												
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that cause ne cause on each li	d the death.	Do not ente	er the mode	of dying	, such as ca	ardiac or respi	ratory arre	est,		Approximate Interval Between	
5	Physician		Immediate Cause (Final disease or condition	2	T	Neu	mo	NI.	w					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):									
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	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
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8760,	cate be executed only sician and the burial-transit	dical		d											
9	entifica ling pl	Med	IF FEMALE:	10 - 11	-4										
Вох	attending for use as	lan/	in the past 12 months?	3c. If yes, outcome 1∐Live birth 4∐Pregnant a	2 Fetal o	death 3 🗌	Ectopic pre						ate of deli Ionth	very Day Year	
o.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown			Cities (spe	,c.i.y/							
<u>a</u>	ires that signed b	y Pł	Part II. Other significant conditions con	ntributing to death b	out not resul	ting in the un	nderlying ca	use give	n in Part I.	23	e. Did tob	acco use co	ntribute to	the causa of death?	
Records,	w require been sig should b	edt	Colles							_	1 🗌 Ye	s 2 No	3 🗌 Pro	obably 4 Unknown	
ecc	e law re has be je 2 sho	piet	Deep Venous	Thronk	365 is					24	a. Was ar	246	. Were au	topsy findings available completion of cause of	
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	fospital:				Othe	_	f Death (Chec	-				
	Phys rthis ral dir	T.	1 Yes 2 No	28a. Date of Inju		R/Outpatient 28b. Time of		A Bc. Injury	4 🔲 140151	ing Home 5		w injury occu	ther (Spec	cify)	
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Division of		Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hon	ne, farm, stre	et, factory,	office		28f. Lo	cation (Str	eet and Nun State)	ber or Ru	ral Route Number,	
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	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Medicel Exami	ner: On the basis of and manner st	of examination	on and/or inv	estigation,	in my op	e, date and p inion, death	occurred at the	e to the ca	use(s) and nate and place	anner as , and due	to the cause(s)	
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3	(6.7)		30. Name and address of p s who co		death (Item	3a) (Type, f	Print) I	D ₁ .	a d	i, d	Sec.	30	700		
đ	Sta	ete	31. Date filed (Month, Day, Year)	32. Registi	rar's Signatu	nue 7 - 2	20	100		Jan	170	To	177		
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State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alice deCoux Blose 10, January 2004 8:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Months 1 □ M 2874 92 Yrs. 202-28-2519 25, 1911 South Carolina Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "neturel", or Iteme 23e or 28e-f ehow other traumatic event, tra Medical Examirier must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9106 River Crescent Drive 21401 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Iten eny injury or other traumatic event, Ita Medical Examina Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No δ Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Musician 4 Teaching 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Southard Hazel Marie Inskeep 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James F. Blose, Sr./husband 9106 River Crescent Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 1/13/2004 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of 59 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINEDITE Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of ir jury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 1 ☐ Yes 2 ☐ No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed res 2 217No 1 Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Other: 1 🗆 Yes 1 🔲 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. May er of Jeath 1 latural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Micertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatule 29c. License number 29d. Datersigned (Month, Day, Year) ANNAPOLIE 30. Name and Red cause of death (Item 23a) (Type, Print) YARKWAU Dr. Kevin O'Keefe 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JAN 1 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JANUARY 2004 2020 M JAMES R. BUTLER, SR. /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CAROLINE APT 5D GREENSBORO 207 MAPLE AVE., If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) NOV • 15 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 10XM 2□ F Yrs MARYLAND Director 80 218-20-5233 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ▼ Yes 2 No Director MD CAROLINE GREENSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Івше 23а 207 MAPLE AVE., APT 5D 21639 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturet", or Itan any Injury or other traumatic event, the Medical Example 2016. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TRANSPORTATION 8 TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDITH CHAPLAIN FLOYD S. BUTLER, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIA C. BUTLER/WIFE 207 MAPLE AVE., APT 5D GREENSBORO, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 01-06-2004 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 () Strough 3/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chrone Obstration Delarana Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ¥ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۴ 1 ☐ Yes 2 S No this After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending I within 24 hours after death.
To the Funeral Director: After 1 Statural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32036 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) Drive Cherto, MO 2/6/9 910317 Duar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar			l / Depa	artment of H	lealth a		ental Hygi	_) l	01496
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21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23e or 28e-f show fre Medical Examiner: wat be motified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	me.	Cannery	-	o **		Food Pr Indu		_
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Ĕ	Pag nent ant: I		'4 □Donation 5 □ Other (Specify)	omova, nom otato	Susc	quenan Garde	ina Memori ens	iai ;	01/1	.0/04 Y	ork, Pe	nnsy	lvania
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Properties of Health and Mental Hygiens Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other treumatic event, the Medical Evantment and the motified at once.		21. Signature of Funeral Service License	98		22 1.6	Name and Addresse A. Pat	ss of Facility	n & s	Son Fune	ral Hom	A I	РΔ
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Division	or A after Direction by	it.	4 ☐ Homicide determined	building, etc	c. (Specify)	no, rami, su	eet, factory, office		-	City or Town		0/1/0/0	a riodio rambor,
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			1 - For State Registrar	State of	of Marylar		artment rtificate				fental Hy	/giene Reg. No.	200) [4	0 !	497
		~	1. Decedent's Name (First, Midd	tie, Last)							2. Date of De	eath			3. Time	of Death
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	Funeral		5. Sociel Security Number	6. Sex	7. Age (In yrs.	, ,	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year								ace (State	or Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty, Town or Lo	cation							1	Od. Inside (City Limits
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(0	riter o	F	1 ☐ Never Married 2 ☐ Mar		2 🗆 No	1			n, Mexicar	i, Puerto	ecify Yes or No Rican, etc.)		Black, \	White,	etc.	
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21215-0036	be itled within 72 hours after death with the Maryland ital Hygiene. In the matural, or items 23s or 28s-1 show event, the Medical Exameter minist be multiped at	Completed		nt's Education est grade completed))	16a. Dece	dent's Usua	Occupa	ition	a of work	in a	16b. Kir	5b. Kind of Business/Industry			
2	within lene. than "	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of wor DO NOT us	e retired,)	t of work	iing					
21	filed w Hygier ther th	ပ်	10			Carpe	enter					-	1ding	<u></u>		7. /
P	be fit d of H	Be	17. Father's Name (First, Middle,						18. Mothe	er's Nam	ə (First, Middle	, Maiden	Sumame)			
<u>Y</u>	should be nd Mental r marked o	P	John Leslie Bio								. Munsh					
Maryland	2 8 8		19a. Informant's Name/Relation:								al Route Numb					
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Ronnie L. Bidd	inger/Son	20b B	418 S			renue		derick,		-			
Baltimore,	0 0 = =		1XXBurial 2 ☐ Cremation		State	emetery, crer	natory or of	her place			Date		cation - City	•		_
ţ	t. Pa tmen rtent: njury		*4 □Donation 5 □ Other (S		Unic	n Chape		_	ļJ	anuar	y 10,200	4 Lib	ertyto	wn,ŀ	aryl <i>a</i> r	rd
Bal	permit. Pag Department Importent: I any injury o		21. Signature of Forest I Service	Licensee							auffer					
	10140		40 Fulton Avenue/ Walkersville, Maryland 2179. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
			snock, or near failure. Lis	t only one cause on	each line.	n. Do not ent	er the mode	of dying							Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Meto	estat	re (111	1210	18	Can	el			now	
	Examiner			Due to	(or as a consequ	uence of):							***			
		er	Sequentially list conditions,	b. — Due to	(or as a consequ	uanaa afti										
	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
	xecu and	Examin	that initiated events resulting in death) Last	C. Due to	(or as a consequ	uence of):										
8760,	cate be executed physician and the burial-transit	dicai E														
687	ficate physis the	edic		d									.			
Вох	that the death certifi ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							2	3d. Date of	deliver	v	
ă	death a atte d for	cia	in the past 12 months?		oirth 2 ☐ Fetal nant at time of de		Ectopic pre Other (spe						Month		-	Year
0	t the or	hys	9 Unknown	9□ Unkn	own											
σ,	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditi	ons contributing to d	eath but not resu	Iting in the ur	nderlying ca	use givei	n in Part I.		23e. Did to	obacco us	e contribut	te to the	cause of	death?
ğ	w require been sig should b	ed t	Congestive	Hear	(av	Ure	_				101	Yes 2/2	ÎNo 3□] Proba	bly 4 🗌	Unknown
00	> 40 (0	ojet	٥								24a. Was	an	24b. Were	autoo	sy findings	available
Vital Records,	Ф г ж	Completed										rmed?	prior deat	to com	pletion of o	ause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medica	al					26 Place	of Death	1 ☐ Yes	2200	10	Yes 2	No No	
	S S	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 🗆 I	ER/Outpatien	3 DOA	Other	-		ne 5 Resid		Other /	Specify		
οl	ding Phy After thi funeral	ü	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury		ic. injury Work			28d. Describe I			speciny)		
<u>Ö</u>	Attending r death. sctor: After by the fune	atic	E / TOO IGOT IT	igation	., ., .,	inquiy	М		es 2□N	No						
Division	r Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At ho	me, farm, stre	et, factory,	office		1	28f. Location (S City or Tox	Street and	Number o	r Rurai	Route Nun	nber,
	itel or rs afte ei Din ed in	Cer								ļ						
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyin	ng Physician: To the Examiner: On the b	best of my know	wledge, death	occurred a	t the time	e, date and	d place, a	and due to the	cause(s) a	ind manne	r as sta	ted.	->
_	the the the h	Med		and man	ner stated.						od at the time,	Gate and	Diace, and	ane to i	ne cause(s	*)
	viti To	=	29b. Signature and title of certifie)T			29c.	License		,		29d. Date	signed (M	onth, D		
•			NWY	7				11	C- 2(1	U		741)	l	200	4
	20		AO. Name and address of person	who completed caus	se of death (Item	23a) (Type, I	Print)	A		Co	20 4	1	5/	201	7-	
			31. Date filed (Month, Day, Year)	150 MD	tegiştrar's Signat	2 1 V	VK/	A	14	(),	SP P	<u>ソ</u>	- (0		
100	Sta Registr		JAN -	8 2004	Senera	1	1	na.	1/2/							

				e of Maryland	/ Depa		ealth and N	lental Hyg	_	04	01498	
	Physici	an	1. Decedent's Name (First, Middle, Last)	als				2. Date of Deat Month		Yeer	3. Time of Death 2:28 a M	
	/Medic Examin		Evelyn Pearl Be 4a. Facility Name (If not institution, give street an Cuppett-Weeks Nursi	d number)		4b. City, Town, or Oaklan	Location of Death		4c. County		2.20 a	
	Funeral Director		5. Social Security Number 232 24 8013 Usual Residence of Decedent	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 12	^{Year)} 1922	9. Birthpi Coun WV	lace (State or Foreign try)	
	e Maryland Ba-f show	ctor	10a. State 10b. County MD Garrett	10c. City, To		Park			10d. Inside City Limits 1 — Yes 2 □ No			
	th with the 23 or 21 set be me	al Dire	10e. Street and Number 607 P St Apt 9			10f. Zip Code 21550		10g. Citizen of Who			itry?	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, Ita Medical Exercitives at the notified at	by Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 (XNo s, Give or Dates:		Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, e y: Whit	etc.	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle		(Give life. L	ent's Usual Occupa kind of work done o DO NOT use retired, acher	tion uring most of work	ing		nd of Business/Industry		
Maryland 2		To Be Co	12 4 17. Father's Name (First, Middle, Last) Byrd Bragg				18. Mother's Nam		Maiden Suman	ne)		
Mary	and and Is m		19a. Informant's Name/Relationship (Type, Print Jane Deaven	7) 1		g Address (Street a W. Church		r or Rural Route Number, City or Town, State, Zip Code) Anneville, Pa 17003				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra		20a. Method of Disposition 1 \$\frac{1}{2}\Burial 2 \subseteq Cremation 3 \subseteq Removal 4 \$\subseteq Donation 5 \subseteq Other (Specify)	IIOIII State		sition (Name of natory or other place netery			20c. Location - Elk Gar	•		
Balti			21. Signature of Funeral Service Licensee	ck		Name and Addres avid A. I 10 Church	Burdock F	tzmiller	Md 2	1538		
	/Medical Examiner	ner	Sequentially list conditions. b	in a caused the death. Let on each line.	ce of):	Y Fo	, such as cardiac	or respiratory arre	est,	١	Approximate Interval Between Onset and Death Apple 4 VS	
3760,	ite be executed nysician and he burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence	ce of):							
P.O. Box 68	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the training the control of the control	Physician/Medi	FEMALE: 23b. Was decedent pregnant in the past 12 rylonths? 1 Yes 2 No 9 Unknown 9 Unkno								ry Day Year	
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing	to death but not resulting	g in the ur	derlying cause give	n in Part I.	23e. Did tob			e cause of death? ably 4 □Unknown	
of Vital Records,	The law re- ate has bee page 2 sho	Completed						24a. Was ar autops perform 1 □ Yes 2	y ned?	Were autor prior to con death? 1 \(\sum \text{Yes}\)	osy findings available inpletion of cause of	
	ding Physician: The n. Atter this certificate hi funeral director, page	To Be	LE HALLIA		Outpatien b. Time of Injury	28c. Injury Work	4 (2-Nursing Ho	th (Check only on the 5 Theside 28d. Describe ho	nce 6 🗆 Oth		')	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could not be	Place of Injury - At home, building, etc. (Specify)	, farm, stre			28f. Location (Sti City or Town		er or Rural	l Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Directory illed in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: 1 Certifying Physician	o the best of my knowled the basis of examination manner stated.	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and ma	anner as sta and due to	ated. the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier Danus	ry Oo.	, Qr	29c. License	number 2615	4 25	od. Date signe	d (Month,)	Oey, Year)	
22	le		30. Name and address of person who completed	cause of death (Item 23)	a) (Type, I	Print)	Klan	I N	10	215	550	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2004	32. Registrar's Signature	K 2	Inches &	,	`				

			1 - For State Registrar	State of Mary		artment of F rtificate of			jiene _{leg. No.} 20	004 01499			
			Decedent's Name (First, Middle, La.	5t)				2. Date of Dea	of Death 3. Time of Death				
п	Physici /Medic		Sylvia H.	Blonder				January	10, 20	004 11•45 Δ ^M			
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Dea	ath	4c. County of Death				
			Anne Arundel Medi			1	apolis			e Arundel			
R	Funeral Director		109-10-9807	9x 7. Age (h	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		Year) 1,1917	9. Birthplace (State or Foreign Country) New York			
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits			
	f she	jo	Marvland Anne Ar	undel	Fd	lgewater				1 ☐ Yes 2 X No			
	28s	Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of	What Country?			
	h with	ai D	322 Colony Point	Place		21037	7		US	SA .			
	dead	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-		ce - American Indian, ck, White, etc.			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-f ehow empty injury or other traumatic event, the Mcdical Exarting high in williad at ODGs.	by	1 ☐ Never Mamied ② 【☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 🎇 No Specify:				y: White			
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of			16b. Kind of Bi	usiness/Industry			
2	within iene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)						
	Hygiel Hygiel Sther ti	S	17. Father's Name (First, Middle, Last)	4 years		Homen		ame (First, Middle,		ome			
Maryland	d be fi	o Be	Joseph Ho					dred Loeb		10)			
2	and Menis marke	으	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or F	Rural Route Number	, City or Town,	State, Zip Code)			
	nd 2 alth a 27 is r trau		Joseph S. Blonder	/ Husband	322	Colony Po	oint Pla	ce, Edgew	ater, M	4D 21037			
Baltimore,	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition		20b. Place of Dispo					City or Town, State			
Ē	Pages nent of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		MD Veter	ans Cemet	ery 1-	13-04	Crownsv	ville, MD			
alt	permit. Page Department Important: If eny injury or once.	ì	21. Signature of Funeral Service Licen	1500	22	2. Name and Addre	ss of Facility G	eorge P.	Kalas F	Funeral Home			
_	20 E 2 9		> promine							er, MD 21037			
7	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	olications that caused the one cause on each line.	death. Do not ent	er the mode of dyin	ig, such as cardia	ac or respiratory arn	est,	Approximate Interval Between Onset and Death			
20	/Medical Examiner		disease or condition resulting in death)	a. Due to (o _{ff} as a co	onsequence of):	- Me		•1		acys			
**	Examiner		Sequentially list conditions,	. Chron	ne ob	rhutio	e pul	monay	drin	re year			
	p ==	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):	1	1)	1			
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	pethy	occlins	~			year			
8760,	icate be executed physician and s the burial-transit	alE		/s	time.	tie				Lipon			
587	phys s the	edicai		d.									
9 xc	certif nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Dat	te of delivery			
. Box	that the death certifined by the attending of detached for use as	Physician/Me	in the past 12 months?	1 Live birth 2 □ 4 Pregnant at time		Ectopic pregnancy Other (specify)			Mo	nth Day Year			
P.O.	by the	hys	9 □ Uпклоwn	9∐ Unknown									
Records, 1	Se 15 6	þ	Part II. Dther significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	1		ribute to the cause of death? 3 □ Probably 4 ÆOhknown			
Ö	w requir s been s should	lete						24a. Was a	n 24b. V	Were autopsy findings available			
æ	The law ate has page 2:	Completed						autops perform	ned? c	prior to completion of cause of death? 1 □ Yes 2██No			
Vital		O	25. Was case referred to medical examiner?				26. Place of De	eath (Check only on		2100			
<u>></u>	Physician: r this certificaral director.	To B	1 ☐ Yes 2 (≥ to)	Hospital: 1 patient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Reside	nce 6 □Othe	er (Specify)			
ח	ding P		27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Work	κ?	28d. Describe ho	w injury occurr	ed			
sio	Attending ir death. sctor: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		At home forms to		Yes 2 □ No	296 Leasting (Ct	an ad a and Africa b	and Control Control Manager			
Division of	al or Attendate after death Director: d in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	еет, тастолу, опісе		City or Town	, State)	er or Rural Route Number,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best of m niner: On the basis of exa and manner stated.	amination and/or inv	n occurred at the time vestigation, in my op	ne, date and place pinion, death occ	e, and due to the ca surred at the time, da	use(s) and ma ate and place, a	nner as stated. and due to the cause(s)			
	To the within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License	,	29	9d. Date signed	(Month, Day, Year)			
•			Hung)	aus mo)	D5	3111		1/10	04			
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)			-1				
			Hung T. Davis 20	001 Medical	Parkway.	Annapoli	s.Md. 21	401					
	Sta Registr		31. Date filed (Month, Day, Year)		Signature	1 10	,						

ORIGINAL

			1 State	State of Maryl	•	artment of H				004	015	00
		1	Registrar 1. Decedent's Name (First, Middle, Last)			timouto or E		2. Date of De	Reg. No.		3. Time of D	Death
п	Physici		Δ 0	dell				Month	O 7	Year OH	1.10	Дм
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death			nty of Death		
	LXamii		university of Man	usland		Pret	nire		BAL	timo	Recity	
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	n	9. BIRD	idiace (State of	Foreign
	Director		317-38-5964	M 2□F	64 Yrs.	Months Days	Hours Min.	3-1-3	9	Ind	diana_	
	۳ ـ		Usual Residence of Decedent	100	City Town and a						40d Jasida Cib.	. I imita
	show	<u></u>	10a. State 10b. County		City, Town or Lo	cation					10d. Inside City	
	88-f	Director	DE Kent	1)over			1	10 000			
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show with the Macical Example or contined at	ā	10e. Street and Number	Rand		10f. Zip Code	04		10g. Citizen		unity r	
	8 23	Funeral	580 Dundee	2. Was Decedent Ever in	0116 123	Was Decedent of His		necify Vec or No	U.5 A		ncan Indian,	
	item item	Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ■ Yes 2 □ No		f Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)		Black, White		
38	irs af	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates: 57	-61	1 ☐ Yes 2 █ No	Specify:		Spe	city: W	hite	
ŏ	2 hou	bed	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occupa	ation		16b. Kind of	Business/l	ndustry	
212	T un	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. I	kind of work done d DO NOT use retired,)	_	6			
2	d with	Completed	12	O0110g0 (1 401 54)	Ser	vice T	rechni	cian	De	ars		
פ	other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	-	Maiden Surr	ame)		
Maryland 21215-0036	should be and Mental s marked o	ToE	Joab Badell				Mart	ra A	771	Z		
ar	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiane. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Marical Examinational banching at		19a. Informant's Name/Relationship (Typ			ng Address (Street a					-	
	and and m 27 m 27		Nathan Badell -	- 200		William	M 2+.,	Cano	•		9934	
ore	ges 1 ar t of Hea if item or other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	amoval from State		natory or other place	9)	Date	20c. Locatio	. 1	_	
Ĕ	Pages ment of I ant: If its ury or o		'4 Donation 5 Other (Specify)	ن المالية	add Fel	lous		12-04	Car	aden	. De	
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License			. Name and Addres				Dove	- D	_
	20E 3 a		hollen Cover				Funera			- 000	er, De	
No.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the d e cause on each line.	leath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Betwo	een
	Physician		Immediate Cause (Final disease or condition	liver-fo	uline						Onset and De	34111
	/Medical		resulting in death)	Due to (or as a con-			•					
	Examiner		Sequentially list conditions.			ual di	secise					
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									
	and trans	cam	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a con:	enguango of):							
80,	be executed sician and burial-transit			Due to (or as a cons	sequence or).							
8760	ate	Physician/Medical	d.									
9 xo	eath certific attending pl for use as I	/Me	IF FEMALE:	3c. If yes, outcome of pre	onancy				0.01			
Bo	atten atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	Ectopic pregnancy				Date of deliv Month	,	ear
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ordeat⊓ 5∟	Other (specify)						
۵.	res that the de signed by the a be detached f	P.	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderiving cause give	n in Part I.	23e. Did to	bacco use co	ontribute to	the cause of de	ath?
Vital Records,	sign d be	d by				, ,		101	es 2 □ No	3 □ Pro	bably 4 Or	nknown
Ö	w require been si should t	ete						04-146-	04	- 146	C. d	
Š	has has 3e 2 :	Completed						24a. Was autop perfor	sy med?	prior to co death?	opsy findings as ompletion of car	use of
<u></u>								1 Yes	2 No	1 🗆 Yes	2 No	
=======================================	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	ospital:		t 30 DOA Othe	26. Place of Dea					
	문 등 E	٦.	1 ☐ Yes 2 ☐ No	28a. Date of Injury	2 ER/Outpatien 28b. Time of	3 000	4 🗆 radising m	ome 5 Resid			ıfy)	
UQ.	After After tune	tion	1 Natural 5 ☐ Pending	(Month, Day Yeer	r) Injury	Work	r?` res 2 □ No	Edd. Dodonos I	ow injury occ	diled		
Division of		lica	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, stre			28l. Location (S	treet and Nu	mber or Ru	ral Route Numb	97.
2	l or Att after d Diract I in by	Certification:	4 Homicide determined	building, etc. (Sp.	ecify)	oot, factory, office		City or Ton			27770010770	
_	spita iours naral filled		29a. Certifier 1. ☐ Certifying Phys	ician: To the best of my	knowledge, death	occurred at the tim	e, date and place	and due to the	ause(s) and	manner as	stated.	
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical	(Check only 2 Medical Examin	er: On the basis of exam and manner stated.	nination and/or inv	estigation, in my op	inion, death occur	red at the time,	date and plac	e, and due	to the cause(s)	
	To th within Fo th compl	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sig	ned (Month,	, Dey, Year)	
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			30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type.		011	Krister		+		
			22 South Greene		Strive	* .	21012	Krister	1 Hz	ustn	1	
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